S. HRG. 109–459

ROUNDTABLE ON METHAMPHETAMINE: FIGHTING METH USE—A COORDINATED EFFORT

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

ON

EXAMINING ISSUES RELATING TO THE USE AND ABUSE OF METHAMPHETAMINES

MARCH 23, 2006 (Casper, WY)

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C O N T E N T S

STATEMENTS

THURSDAY, MARCH 23, 2005

ADDITIONAL MATERIAL

ROUNDTABLE ON METHAMPHETAMINE: FIGHTING METH USE—A COORDINATED EFFORT

THURSDAY, MARCH 23, 2006

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 1:30 p.m., at the Holiday Inn, 300 West F Street, Casper, Wyoming, Hon. Michael Enzi, chairman of the committee, presiding.

Present: Senator Enzi.

OPENING STATEMENT OF SENATOR ENZI

Senator ENZI. I'll call to order this roundtable on the forum of use and abuse of methamphetamine.

Today's roundtable is a hearing of the U.S. Senate Committee on Health, Education, Labor, and Pensions, and our findings today will be a part of the committee's official record on this issue.

I will mention to all of you, if you submit statements, they will all become a part of the record. As we go through the process today, if you think of something that you do not have a chance to comment on or you want to expand on something that you've said before, we want you to submit that for the record as well.

We're trying to gather as much information as we can to solve a problem. It is a huge problem across the Nation. Of course, yesterday State Senator Bob Peck gave me the paper that he had just put out, and it says "Abuse Killed Child, Says Pathologist." If you read that story, it tells a little bit, a little bit about what's happening with methamphetamine use, and that's not an isolated story.

Today we'll be taking a closer look at the drug problem our children face every day, and methamphetamine which now appears to be the drug of choice for too many of today's young people.

It can't be said any more clearly. Methamphetamine is a lie. It destroys everything it touches. It promises to deliver fun and good times to our children, but, in the end, all it does is steal our hopes and dreams for the future leaving nothing behind but pain and heartache.

It's a scourge on every level of our society, and we must not ignore or minimize the damage it does to our families and communities.

If we're to effectively fight the use of this drug, we have to take a team approach that includes our leaders on the local, State and

national level as well as law enforcement organizations and their personnel. One of the reasons I'm really happy to be holding this hearing here is because we need to be sure that the rural aspect of solving the problem is a part of the national solution, and I know that the most creative people in the whole world are the people from Wyoming. I appreciate everybody that's from Wyoming or come to Wyoming to contribute to this solution that we'll have here today.

I should mention that the record will stay open for 10 days after the hearing is over, and that will allow other members of the committee who aren't able to come to Wyoming for the hearing to be able to look at the testimony that has been received and ask some additional questions that might hone in more on their area of expertise.

There is no doubt that it's time to draw the line on meth use and make sure our children understand that it's a dangerous drug and they should avoid it, even avoid it the first time. It's not an experimental drug. We must speak up now and make sure they hear us before it's too late.

Now, as the proud grandfather of a grandson, I'm very concerned about the world that he'll grow up in. That's why the statistics on meth use are of such great concern to me and other parents and other grandparents all over our State and the Nation.

According to a July 2005 report by the National Association of Counties, meth use has been named America's No. 1 drug problem. We also know that meth hits places like Wyoming the hardest. Rural areas in the western and midwestern parts of the country have been reporting use well above the national average.

Part of the reason I think that happens is that we have more of a sense of community than the rest of the Nation, so we're more concerned about our friends and neighbors, and so the problems show up in the smaller populations. But it's a huge problem. We need to solve it here and everywhere else.

For those who don't know, meth is a powerful stimulant that affects the central nervous system and can cause an individual to become aggressive, confused and paranoid. It causes parents to choose getting high instead of caring for their children. The result of meth use is an increase in crime and an increase in abused and neglected children in these areas. The strain on local law enforcement, health care services and businesses is severe. In response, we need a comprehensive, coordinated approach to assist cities and towns all over the Nation.

Thanks to the leadership of Senator Talent of Missouri, Congress sent to the President the Combat Meth Act, which the president signed into law this month. This new law restricts the sale of ingredients needed to make meth. It enhances the international enforcement of meth trafficking and it provides tools and resources to law enforcement to crack down on meth producers and distributors. It's a much needed and important step forward, but there is a lot more we can do.

The reason I'm holding this roundtable is to better understand how to coordinate with the States and localities to treat and prevent meth use and abuse. For every dollar spent on treatment, so-

ciety saves $7 in reducing the need for medical attention, jail time, environmental hazards and child welfare.

As chairman of the Senate Committee on Health, Education, Labor, and Pensions and as someone from a State where over 50 percent of all drug arrests are meth related, I'm concerned about the impact this fiercely addictive drug has on rural and frontier communities and families.

In the end, the answer to stopping the spread of meth use will not come from Washington. The answer will be found by the individuals, the communities and the States most affected by the impact of this drug.

Fortunately, several States are already stepping to the plate to get ahead of the problem. Montana has the Montana Meth Project that aims to significantly reduce the prevalence of first-time meth use in the State through public service messaging, public policy and community action. This is a coordinated effort that's working.

South Dakota has launched the Methamphetamine Awareness and Prevention Project which encourages communities to form coalitions of citizens, businesses and community leaders, law enforcement and faith-based organizations to examine meth issues in their area. Working together, they develop projects to increase the awareness of the dangers associated with meth and educate the public on how they can become involved. It's the only project of its kind in the United States.

We will hear today what Wyoming and Utah are doing. These States are among the leaders in the fight against meth.

I welcome this chance to look at the different initiatives that are proving effective, coordinated efforts from different communities, regions, States and levels of government.

The Substance Abuse and Mental Health Service Administration is working with the States to develop national performance outcomes measures. This is a State-level reporting system that will create an accurate and current picture of substance abuse. Once all States are on the system, research will be more rapidly translated to care.

Until that picture is complete, we must work to ensure providers are getting and using the most up-to-date information on treatment based on the best evidence available.

Treatment for meth has proven to work and States are finding ways to beat meth use and abuse. The Federal Government must work to support these efforts, and that's what I want to discuss with you today. Need your ideas. The way these roundtables work, it's a little different system than what we have used in Washington before.

As the chairman of a committee, I'm allowed to call hearings, and the typical hearing would be to have one or two panels of five or six people. The reason they're that big of a panel is I would get to choose all but one of each panel and the ranking member would pick the other person. Then we would have a bunch of people from both sides of the aisle show up to beat up on the people that were doing the hearing. It isn't really meant to be an attack on the people, but quite often it turns out to be an attack on each side of the aisle.

Senator Kennedy and I have gone to a system of roundtables, and that's where we invite in some people that are experts on the situation and we discuss some common questions to come up with some common answers, common sense answers. We found that that works much better. It eliminates some of the animosity that comes out of the hearings and actually allows the Senators to listen and hear what the suggestions are instead of concentrating on the kinds of questions that could be used to embarrass or further their particular viewpoint.

I really appreciate the group of people that we have here today, just a tremendous, tremendous resource. Many of you I have gotten to visit with before and look forward to the information.

As I mentioned, any statements that you want to submit will become a complete part of the record and anything you want to expand on later will also be a part of it.

To make the roundtable work, what we ask is that when you want to speak, if you would raise your card. I'll have some help from people helping to keep track of what order they're raised in so that we can be as fair as possible on that.

Since we already have your statements, it wouldn't be necessary to put the entire statement in there. We would ask, to get as many ideas out as possible, that you limit your comments at any one time to about 2 minutes or less, and that way it becomes more of a rapid fire kind of brainstorming.

I would like to introduce the people that we have on our panel today. I would like to start with the First Lady of Wyoming, Nancy Freudenthal.

I got to spend the day yesterday with your husband, and it's nice to have you with us today. It's really an honor to have you here.

I could be wrong, but I believe this is the first time that a Senator from Wyoming has chaired a U.S. Senate committee hearing to hear the testimony from the first lady of our State. This is kind of an historic occasion. The first lady will be talking to us about her First Lady's Initiative.

It will be a little bit of a variance from it, but we're talking about substance abuse and mental health, and one of the substance abuse areas is definitely in the area of underage drinking as well as alcohol abuse, but the First Lady's Initiative has been aimed to prevent underage drinking, and we want that to be a specific part of the testimony on this.

I appreciate your being here with us today.

We also have Anna Maki, the meth initiative coordinator for Wyoming, the Substance Abuse Division in Cheyenne.

We have H. Westley Clark, the director for the Center for Substance Abuse Treatment for the Substance Abuse and Mental Health Services Administration in Washington, DC.

We have Tom Pagel, who is the chief of police here in Casper, and he's also a member of the citizens committee work group and he'll be speaking more about their work.

We have Dr. Robert J. Fagnant, who is the OB/GYN doctor at the College Hill Women's Health Center in Rock Springs.

We have Mr. Jim DeLozier, who is the district manager for Natrona and Carbon County Department of Family Services also here in Casper.

We have Sherry Martin, who is the director and CEO of Family Wholeness here in Casper.

We have Margean Searcy, who joins us from the Salt Lake City Police Department.

We have Mr. Rod K. Robinson, who is the executive director of the Wyoming Substance Abuse Treatment and Recovery Center in Sheridan.

We have Doug Noseep, who is the chief of police for the Wind River Reservation.

We have Bill Sniffin, who is the CEO of Wyoming, Incorporated in Lander and is also the founder of Free and True, the antimeth campaign that's been working well here in this State, and looking forward to hearing some more about that.

We have Dr. Grant Christensen, who is a dentist from Rock Springs who devotes much of his time traveling around the State to work with individuals with meth mouth.

We have Sergeant Steve Hamilton, who is joining us from the Campbell County Sheriff's Department located in my hometown of Gillette.

And, last but certainly not least, we have Dr. Richard K. Rawson, who is the executive director of the Matrix Center and the Matrix Institute on Addiction and deputy director of UCLA Addiction Medicine Services located in Los Angeles.

Let me turn to the first question for the participants. What work have you done in your perspective field or community to better understand and successfully address meth use in rural areas? Emphasis on the rural areas and, again, in your perspective field or your area of interest.

Who wants to be first? Mr. DeLozier. Again, I'll interrupt you just before you start.

When you think of something and you want to be recognized, stand your card on end, and that will help us to know what order to go in.

Mr. DeLozier.

STATEMENT OF JIM DeLOZIER, DISTRICT MANAGER, NATRONA AND CARBON COUNTY DHS, CASPER, WY

Mr. DELOZIER. Thank you, Senator.

In Natrona County, the Department of Family Services is working in the significant collaboration with law enforcement, the district attorney's office and other public and private agencies to bring meth cases involving children into the juvenile court system where the issues of safety, permanency and well-being can be formally addressed for children and families.

DFS statewide is developing policies to deal with meth cases including policies regarding safety to workers who are investigating and involved in these cases.

DFS is attempting to expand the number of foster homes statewide to deal with the increase in out-of-home placements resulting from meth-endangered children cases. Also we are making use of many more relative placements and kinship placements so these kids have the ability to go with people they know. The legislature recently passed significant increases in the rates for foster parents. This should help in our recruiting for these situations as well.

We have a number of partnerships throughout the community that we're involved with. We refer many cases for counseling assessments, all of those kinds of things to the Central Wyoming Counseling Center here in Casper.

We're involved in the planning and the participation for the annual meth conference that's held in Casper, and we are also on a number of other community meth groups dealing with different issues. For example, one is infants born at the hospital with methamphetamine in their system and how we address that as a community.

That's all I have at this point. Thank you, Senator.

Senator ENZI. Thank you.

[The prepared statement of Mr. DeLozier follows:]

PREPARED STATEMENT OF JAMES W. DELOZIER

Methamphetamine (meth) has become a major contributor to child abuse and neglect in my service area as well as the whole State of Wyoming. In the year 2005, approximately 100 children were put in out of home placement due to Methamphetamine use/sales/manufacture in Natrona and Carbon Counties. Most of the issues involved use of the drug and proximity of the drug and associated paraphernalia, to children in their homes or other areas.

Methamphetamine has been attacked in a number of ways in Natrona County. With the introduction of the Drug Endangered Child Act in Wyoming Statute in 2004, Natrona County Law Enforcement began a very aggressive focus on enforcement. Enforcement in Natrona County had been good prior to the introduction of this legislation. Many more children were removed from meth abusing parents or caretakers after its enactment. Law Enforcement, the District Attorney's Office and DFS have worked extremely well together in this area, along with many other agencies. Significant prosecution of cases in both the Criminal and Juvenile Courts has enabled the system to focus much attention on meth issues in Natrona County.

Natrona County has a significant amount of agencies and services available to deal with the front end of the problem, although adequate personnel appears to be a continuing issue for those agencies on the front lines.

The goals in all of the DFS cases were reunification with the parent(s) or caretakers from which the children were removed. Success occurred in cases where high amounts of child visitation with the parent (if safe to do so) occurred in conjunction with intensive treatment, in-patient or out-patient and the parent's willingness to get sober and seek help. Most of the children involved were under 10 years of age and most of that group was under 6 years of age.

DFS worked its cases much the same way in Carbon County. However, by contrast, Carbon County is composed of very small, low population communities. Adequate resources to attack the meth problem on the front end are lacking in most of the agencies involved, and even basic treatment resources are just short of nonexistent. This kind of problem exists in much of Wyoming in dealing with the meth problem.

A major issue is availability of treatment resources. Even in larger communities like Casper and Cheyenne, adequate treatment resources do not exist, particularly when it comes to low-cost or no-cost residential treatment for adults. Most of the adults involved with meth in the DFS cases have no ability to afford residential treatment.

Casper began addressing the meth problem over 5 years ago. The community is poised to see continuing growth in knowledge and participation in dealing with meth issues for a long time to come. Other communities in Wyoming are just beginning that journey because of increased meth presence in their areas.

DFS has formed partnerships with a number of entities/agencies in Natrona County in tackling the meth problems. We form part of an overall safety net in which each player has a role. Some of the partners DFS works with are: Casper, Mills and Evansville Police Departments; Natrona County Sheriff's Office; Natrona County District Attorney's Office; Central Wyoming Counseling Center; Natrona County Child Advocacy Project; Natrona County Public Health Department; Natrona County School District #1; Wyoming Department of Corrections; and Community Health Center of Central Wyoming.

This is a sample of what good cooperation and communication can accomplish. There are 2 recent involvements to highlight.

1. Natrona County Child Advocacy Project.—DFS, along with many other partners, is a member of the CAP, and has been for several years. The main purpose of the CAP is to provide a safe environment in which to provide forensic interviewing services, medical and mental health assessments, of alleged victims of child abuse. Most of the cases coming to CAP had been sexual abuse and major injury cases. As of March 1, 2006, CAP initiated a meth protocol. Now any child coming into DFS custody because of meth will automatically go through the center to receive a forensic interview for information/evidence gathering, a medical assessment to include the Well Child Check DFS is required to have on all children coming into custody, and either a mental health assessment or child developmental screening depending on the age of the child as to which is appropriate. Developmental screenings would be referred out to Child Development Centers. CAP is currently a program of the Community Health Center.

2. DFS/Department of Corrections/Law Enforcement/District Attorney's Office.—These agencies began a cooperative program of aggressively targeting meth users who are on either probation or parole. DOC has broader powers of search available to them in these cases. Once meth has been determined present in the home or being used by the DOC client, and there are children in the home, the normal procedure of removing children from the home and initiating criminal and juvenile court action comes in to play. This has been an effective tool for the community in dealing with meth use as well.

RECOMMENDATIONS

- Recognize the methamphetamine problem as a health crisis, not simply a substance abuse issue.
- Increase funding availability for Community Mental Health Centers to expand in-patient and out-patient treatment programs across the State.
- Allow funding to be used with private service providers for mental health assessing, screening and treatment without the strings of Medicaid attached. Many private service providers do not wish to deal with the regulations and administrative work associated with Medicaid, especially individual providers.
- Approve funding specifically for getting adults into in-patient residential treatment. Provide funding for women to enter treatment with their children still in their custody. This would require programs to be developed on a larger scale to accommodate women and children.
- Provide incentives for necessary providers to set up shop in remote, low-populated areas in order to increase access and availability of services in rural areas.
- Provide funding availability to projects like the Natrona County Child Advocacy Project to assist in dealing with child abuse/neglect issues arising from meth use by parents or caretakers.

I hope this information will assist Senator Enzi and the committee in making decisions that will provide for positive outcomes related to methamphetamine problems in Wyoming.

Senator ENZI. The next person would be Mr. Pagel. I want to thank him for the document that you gave us that has a lot of information. It will also be a part of the record. Mr. Pagel.

STATEMENT OF TOM PAGEL, CHIEF OF POLICE, CASPER, WY

Mr. PAGEL. Senator, thank you very much.

It's important to note that Wyoming has been dealing specifically with meth since 1992 when it began a rapid rise in its impact on the State. Specifically——

Senator ENZI. Let me interrupt just a minute.

Is everybody able to hear? Do we need to move the microphones a little closer?

Thank you.

Mr. PAGEL. Normally I'm not that bashful. I thought they would be able to hear.

We have been dealing with meth since 1992 when we specifically noted the increase in it and the problems that are brought to us. Since that time, we have tried a very high level of enforcement ef-

forts. We have certainly had success with the enforcement, but we have not had success in knocking the problems out.

What you are seeing now in Wyoming is a meth conference that's sponsored each year with in excess of 700 attendees where we're able to bring in area experts from around the country such as Dr. Rawson, who was here earlier this year.

In Casper we have also taken—with the community money as well as foundation money, we were able to do a study which established a snapshot in time, if you will, of what is the problem in Casper, what is the level of the problem or the scope of the problem that we're seeing.

From that information, we were able to go to a community facilitation initiative where we were able to bring 20 of our citizens together and in an intensive 3-week process looked at the problem in Casper where we have identified problems with the lack of long-term residential treatment centers, a lack of standardization of data and the ability for individuals to get into treatment when they're needed. The capacity is simply not there for residential treatment.

Thank you.

Senator ENZI. Thank you.

[The prepared statement of Mr. Pagel follows:]

PREPARED STATEMENT OF THOMAS J. PAGEL

In 1992, when Wyoming first noticed the increase in the use of methamphetamine, no one could have predicted the tremendous impact that it would have on the State. It now drives our crime statistics, limits our workforce, tears apart families, medically impacts our babies, inhibits learning potential, and wastes untold community and State resources.

Individuals initially looked at methamphetamine as a law enforcement problem. Thousands of drug arrests, high level drug conspiracy investigations, and longer prison sentences failed to solve the problem. It became readily apparent that we could not arrest our way out of this problem. We cannot break the cycle of criminal activity until we break the cycle of substance abuse.

Regional Drug Enforcement Teams (RETs) have been very effective at targeting upper level methamphetamine dealers and removing these individuals from our streets. These cooperative task forces employ Federal, State and local officers and combine their resources. Their efforts have taken thousands of pounds of methamphetamine off of our streets.

Drug Courts have proven to be effective but are limited by capacity availability. The authority of the judge, coupled with effective treatment and long-term monitoring make a difference. In many situations, however, their success is limited because long-term residential treatment is simply not available.

Various prevention programs have been tried in our schools and communities. Most people believe that prevention makes sense but the impact of the programs are hard to evaluate.

Like other western communities, Casper searched for an answer to the methamphetamine epidemic. During the summer and fall of 2005, a research study was conducted in Casper to determine the extent of the impact of methamphetamine. The consultants interviewed individuals from approximately sixty (60) agencies or programs in Natrona County. This multidisciplinary approach gave an accurate "snapshot in time" of the problem.

Armed with this information and foundation funding, Casper put together a Community Facilitation Initiative Committee to examine the problem. The twenty (20) community members spent three (3) intensive weeks reviewing the study and listening to presentations from many experts in the area of methamphetamine. At the conclusion of their review, they made over eighty (80) recommendations to address the methamphetamine problem in Casper.

The collection, warehousing and analysis of data presents a particularly challenging problem. There is no standardization of software for the collection of substance abuse data. This is especially true when you try to combine and analyze data from multidisciplinary professions, such as criminal justice, treatment providers,

medical, schools and social services. Without standardized reporting, it becomes a crisis every time a report or study is attempted.

Casper has made a bold move by promoting random drug testing within the business community. Over 160 businesses have signed on with the program and the number continues to increase. This sends a clear message that if you want to work in Casper, you must be drug free.

The ironic piece of this effort is that with the exception of public safety and commercial drivers, Federal interpretation is that random drug testing of governmental employees is a warrantless search and it is illegal. A community or governmental entity must show that a "substantial need" exists before governmental employees can be randomly drug tested. Isn't it ironic that the bus driver who transports your child to and from school is drug tested but the teacher that spends all day with them is not? Isn't it ironic that the ambulance driver is drug tested but the nurse or doctor is not. This is a ridiculous situation that must be addressed. Governmental employees should not be a protected class but rather, should take the lead in random drug testing.

All of us are accountable for the funds that we obtain and for the responsible expenditure of those funds. This is particularly true of the millions of dollars that are appropriated each year for substance abuse. Unfortunately, confusion exists as to how much money is received, who received and where it will be spent. Funds are received through grants in criminal justice, treatment, prevention and others but it is difficult to determine how much money actually comes into a community because no one entity is in charge.

The RETs have operated successfully since 1987 with funding from the Federal Edward Byrne Grant. This was possibly the most effective Federal law enforcement program I have seen in my 35 years of law enforcement. A State or community could evaluate their needs and determine which of the 28 funding areas were most appropriate for their needs. Unfortunately, the tragedy of September 11, changed all of that. Now the Justice Department funding has shifted to Homeland Security and the parameters have narrowed considerably. While September 11 was an unspeakable tragedy, diverting funds from drugs and violent crime programs in the Justice Department was not the answer. Those funds are needed every day to conduct drug and violent crime investigations across the country.

One of the more significant problems that the methamphetamine epidemic has caused is the lack of treatment beds for long-term residential treatment needs. The old 28 day treatment programs that have historically been used for alcoholics are not effective with meth addicts. While long-term residential treatment programs are expensive, they are certainly a savings over prison incarceration costs and multiple unsuccessful attempts in short term treatment programs. Long-term residential treatment capacity must be increased.

The Health Insurance Portability and Accountability Act (HIPA) complicates the sharing of patient information among the multidisciplinary agencies that are necessary to address the needs of substance abuse addicts and families. This takes a cooperative effort and the necessary information must be available to all parties. This has been encountered in several areas, including pregnant mothers who are using meth and about to deliver their child. The Obstetrics doctors have confidentiality issues with their patients but the Pediatrician doctors and family service case workers deal with the meth impaired babies. Better coordination must take place.

Service providers and program managers must be careful to use "best practices" whenever possible. This might be the surest way to provide effective services to the clients. The problem often becomes how to conduct the assessment, evaluation, and accountability of these programs. Assistance in these areas would be very beneficial to all concerned.

The greatest treatment programs in the world will be unsuccessful if the individual completes the program and is unable to earn a living wage. Workforce development must be an integral piece of treatment programs so that clients can create a new life.

There is no way that the Federal or State Governments can solve the substance problems for our communities. It is possible, however, for grants from the Federal and State Governments to facilitate successes with substance abuse efforts in communities after those communities have conducted assessments and evaluations and then prioritized their responses. There is a role for Federal, State and local Governments, as well as foundations. It is this collaboration that we must achieve.

Senator ENZI. Mr. Noseep.

STATEMENT OF DOUG NOSEEP, CHIEF OF POLICE, WIND RIVER RESERVATION, BUREAU OF INDIAN AFFAIRS

Mr. NOSEEP. Thank you, Senator, for having me.

Indian country, the Wind River Indian Reservation comprises two tribes, the Eastern Shoshone Tribe and the Northern Arapaho Tribe.

I arrived at the Wind River Reservation in 2003 as the chief of police, and it was evident at that time that we were behind the curve. As Mr. Pagel said, methamphetamine has been out but it was like a delayed reaction on the reservation. Once they got a hold of it, it took off like wildfire. For us to combat the problem, we teamed with the Department of Criminal Investigation, and they offered us slots and a computer and an office at the Riverton police department.

We essentially took a man off the street for us, a patrolman, and teamed him with the Department of Criminal Investigation.

I know there is—Indian country, it's funny in that they're pretty protective of their areas. Differences aside, meth is not going to wait for you to work out your differences with counties, States, and those are differences that you have to set aside when it comes to methamphetamine.

That is what we had done at the time. We have an officer that is on, that is very aggressive along with the DCI team, and it has been very, very effective.

As you know, May of last year, we had 28 search warrants conducted on Fremont County territory, 7 or 18 of those conducted on the reservation.

We feel that, as Mr. Pagel said, we're not going to get rid of it, but we're definitely, I guess, kicking a hole in it and we're not going to stop now.

Sometimes in Indian country, there is a lot of one-trick ponies, but we're wearing it for good and we're not going to stop.

Thank you.

Senator ENZI. Thank you.

Mr. Robinson.

STATEMENT OF ROD K. ROBINSON, EXECUTIVE DIRECTOR, WYOMING SUBSTANCE ABUSE TREATMENT AND RECOVERY CENTER (WYSTAR), SHERIDAN, WY

Mr. ROBINSON. Thank you, Senator, for the invite to this roundtable.

In the treatment industry, or in the whole realm of developing recovery services, where we stand as a full continuum service treatment center or treatment system in Sheridan, Wyoming, we service individuals from 18, primarily 18 out of the 23 counties in the State. What we have seen as our first task is to first develop a seamless continuum of care that allows for multiple levels and intensities of service rather than a one-size-fits-all model.

Second piece would be that we stay very busy establishing local as well as statewide partnerships from DFS to primary medicine, not just in the area of detoxification, law enforcement. When we establish a full continuum of service, and the research bears it out, that full continuum service is going to be most successful in whatever drug it is that you're treating versus segmented service, either

residential only or outpatient only, too short-term of service or perhaps even too long-term of service where you start to experience what we refer to as therapeutic peaking or folks leaving treatment prematurely.

Our emphasis has been in building a full continuum of service so that you can match the intensity of the person's illness with the intensity of service that will best stabilize and then to follow them for the necessary period of time rather than a predetermined or prescribed period of time, i.e., 6 months only in a residential center versus 18 months, upwards of 2 years with a continuum of service.

We have also worked very hard at embedding the research and performance measures into this particular model so that we can determine what is most appropriate for somebody, whether it's alcoholism or cannabis addiction or methamphetamine addiction, what is the most appropriate length of stay for that individual rather than looking to West Coast or East Coast to help us determine what's most appropriate for Wyoming.

We borrow from those models as there are several great models out there and develop our service system so that we make sure that we're addressing the specific needs of Wyoming citizens, especially in a rural area.

The continuum of service is oftentimes very difficult to establish and sustain in rural areas. However, that's where the strategic partnerships become most critical, and a constant effort, whether it be working with colleagues in law enforcement or DFS, medicine, psychiatry, we make sure that the necessary linkages are in place. I ought not forget the importance of workforce developments as well, because we have such a booming industry in the State right now, but one of the key critical elements that can harness most in that type of industry is incidence of prevalence of methamphetamine use, abuse and dependency.

Really partnering strongly with workforce development is an absolute key that we have been very active in as well.

More for later. Thank you.

Senator ENZI. Thank you.

[The prepared statement of Mr. Robinson follows:]

PREPARED STATEMENT OF ROD K. ROBINSON

WYOMING, A UNIQUE RURAL PERSPECTIVE

Senator Enzi, I would like to start by thanking you and the other members of the Senate Health, Education, Labor, and Pensions Committee for holding this critical roundtable discussion here in Casper, Wyoming.

For the record, my name is Rod Robinson, and I am the Executive Director of the Wyoming Substance Abuse Treatment and Recovery Center based in Sheridan, Wyoming.

Senator Enzi, I think this roundtable discussion is important not just because it's focusing on meth, but specifically because it's focusing on the issue as it relates to rural areas like Wyoming.

If you take a look at the map I've handed out, you'll see the location of NIDA-funded addiction-based research projects in America. Now take a look specifically at the blank area including Wyoming and the surrounding States.

Therein lies the problem. While our States have unique attributes and are affected in unique ways by problems such as the methamphetamine epidemic, far too few resources are expended attempting to understand the unique situations presented by rural States like Wyoming.

That's why this roundtable is so important.

Senator Enzi, I want to start out by commenting briefly on WYSTAR's experience in treating methamphetamine addiction in rural Wyoming.

The first thing I want to emphasize is the importance of providing a seamless full continuum of care when treating methamphetamine addiction, rather than segmented levels of care. There are some who believe that methamphetamine addiction can only be beat with primary residential care lasting 6 to 9 months or longer.

That's just wrong.

WYSTAR is demonstrating that people addicted to methamphetamine can recover with primary treatment stays as short as 60 days. The key is that it does not work to treat an addict for 60 days and then to wish them luck and hope they don't relapse. At WYSTAR, we have conscientiously designed a full continuum of care that ranges from immediate intervention and primary treatment, to transitional treatment with recovery home living, to outpatient services, workforce development and life skills development. (see service matrix handout)

With this type of stepped-down treatment, we can stay with our clients for a much longer period of time at a fraction of the cost of primary treatment. By staying with our clients over a longer period of time, we are able to identify and correct relapse stressors thereby increasing the number of recovery successes.

This brings me to my second point, the importance of follow-up and data collection.

For far too long, treatment providers have been paid for filling beds with little regard for the effectiveness of their treatment.

At WYSTAR, we have concluded that unacceptable. Without data documenting the relative effectiveness or ineffectiveness of treatment, providers are simply throwing darts at a target while blindfolded in hopes that they hit something. At WYSTAR, we have taken the UCLA model for tracking clients and have adapted it for rural Wyoming. Using this adopted model, we have achieved 100 percent success in tracking our clients over a 6-month term.

While SAMHSA has recently reduced follow-up requirements from 12 months down to 6 months, our goal is to continue tracking 100 percent of our clients for 12-months and beyond. It's only by monitoring long-term success that we can be sure that we are making a difference. On this front, one of the lessons that we have learned is that rural Wyoming is significantly different than inner city settings when it comes to client follow up. Think of the adage that Wyoming is a small town with long streets.

That pretty much defines the difference.

We believe that we can attain much higher contact and follow-up rates than the national average precisely because Wyoming is basically a small town. When a client moves, even if they move 2, 4, 6 hours away, their friends, co-workers and family tend to know where they are.

In an inner city setting, if a client moves out of their neighborhood, it may be virtually impossible to find them again to track their progress.

But while our small-town attributes may be an advantage, the liabilities associated with our long streets should not be underestimated. Unlike an inner-city setting, it takes significant time and money to follow up with our clients. In an inner city, a caseworker may be able to visit three or four clients on the same city block.

In Wyoming, we may be able to visit only one client in a day if we need to drive over the Bighorns to Tensleep to see that client. The flip side of that coin is that a client who is about to relapse in Wyoming has significantly fewer options to get to treatment both because of the great distances involved and because the relative scarcity of resources.

This brings me to my next point on rural best practices—the importance of helping clients to establish where their craving thresholds will most likely manifest.

At WYSTAR, we are expending significant effort to identify craving thresholds in users of methamphetamine.

By identifying the duration between craving thresholds during the recovery process, we can better shape the type, intensity, and timing of the services we deliver. By better targeting our resources, we can make the full continuum of care more cost-effective and can also minimize the chances that a client will relapse when they are too far from treatment to seek help.

That brings me to the final point I want to make: the importance of establishing a quality practices initiative pilot program in the reauthorization of SAMHSA that coincides with the National Outcome Measures.

We believe that it is critical that we explore options to make systemic changes to the ways that treatment and recovery services are delivered in America and specifically the ways that those services are delivered in rural America.

What are the structures that we need to put in place to ensure that outcome-based performance measures are incorporated into everyday practices?

How can we ensure that State substance abuse divisions, departments of corrections, family services, workforce development agencies, and education departments all coordinate their approaches to addictions treatment and recovery and to data collection via a comprehensive plan?

How can we make sure that innovative practices identified by providers such as WYSTAR are rapidly distributed to similarly situated providers?

How can we make sure that best practices are provided in real-time to providers and not written up in a TIP that may be published 2 or even 3 years after the data was collected?

Senator Enzi, please know that as you and the HELP Committee consider these and other critical issues involved in the reauthorization of SAMHSA, WYSTAR will do all that we can to assist you and to make our data and results available to you and your staff.

Once again, let me thank you and the other members of the HELP Committee for holding this important roundtable in Casper, Wyoming.

I'm happy to answer any questions that you may have.

Senator ENZI. Ms. Maki.

STATEMENT OF ANNA MAKI, METH INITIATIVE COORDINATOR, WYOMING SUBSTANCE ABUSE DIVISION, CHEYENNE, WY

Ms. MAKI. Thank you, Senator Enzi.

Michelle, thank you for putting this together, as well as everyone, thank you for being here today at the field hearing.

Like Mr. Pagel mentioned, our efforts specific to meth began in 1992. As between 1992 and 1998, meth investigations increased over 600 percent in our State.

The Governor's board, the Substance Abuse and Violent Crime Board took action at this time and sought for Federal funds in order to study this problem. Then it followed in 1998 with the Wyoming Meth Initiative, which was instigated following a Wyoming legislature.

Funds were allocated at this point for improvements to the Department of Corrections, Family Services, the attorney general's office as well as the Department of Health and substance abuse divisions.

Our substance abuse division was initiated in 2000 in order to provide basically more resources to look at this problem called methamphetamine.

In 2005 Wyoming legislators really did respond in force when they looked to authorize a study to review the scope of methamphetamine through House bill 275.

I assisted in this study, the meth planning study, and it really is one of the first of its kind. It is a compilation of data sources that already were existing within the State, set aside maybe one survey that we did complete. This is data sources of the State agencies, local communities across the State. It's quite an accomplishment of information.

Now, the national association of model State drug laws actually looks at this study as a good model of what States can do with already existing data.

Our meth study did provide some means of providing a road map for House bill 308. Now, House bill 308 was aimed at antimeth efforts across the State. We're looking to boost law enforcement, the court system, as well as treatment and prevention across Wyoming.

One of the integral components of Wyoming's statewide response to meth is definitely the progression of gateway drugs. We're talking alcohol, nicotine, as well as marijuana.

We have got multiyear prevention measures in Wyoming. They're working both on alcohol and nicotine, which both sustained steady decline in our State.

The building treatment capacity maintaining a quality continuum of care is also very much key to Wyoming's response. SAMHSA reports that in Wyoming residential treatment has—or the admissions for amphetamines has definitely increased. Between 1992 and 2004, it's increased over a thousand percent just in Wyoming.

Wyoming Access to Recovery has developed a collaboration of criminal justice, treatment and faith-based communities that are providing treatment as well as recovery support services here in Casper. This is aimed at use as well as their families.

We have made some strides as far as closing the treatment gap, but definitely, and you'll hear this today, a shortage of treatment that's specific for meth still is found here in Wyoming.

I think that we're all keenly aware of meth in our State, and the media coverage today is vital in helping us to get this message out.

We have definitely not minimized talking about the problem, and we have openly committed to taking action as we have acknowledged the severity of meth here in our State.

Businesses are beginning to drug test. You'll hear about that today in Casper I'm sure. We have got some strong community initiatives that are coming up all across the State. Again, you'll hear about that. In Casper, in Cheyenne, these community initiatives are key. We need to support these initiatives.

We do have some good news today, too. Wyoming high school meth use has decreased in just 2 years, between 2003 and 2005, from 11.6 percent to 8.5 percent. This is the use risk behavior survey.

It's my feeling that we need to celebrate the success but we certainly can't miss a stride in this fight against methamphetamine.

Thank you.

Senator ENZI. Thank you.

[The prepared statement of Ms. Maki follows:]

PREPARED STATEMENT OF ANNA MAKI, M.S.

Question 1. What work have you done in your prospective field/community to better understand and successfully address meth use in rural areas?

Answer 1. Our efforts specific to methamphetamine began when meth investigations increased by over 600 percent in our State between 1992 and 1998.[1] [2] With such an alarming increase in meth associated problems, it became urgent to mount a statewide response. The Governor's Advisory Board on Substance Abuse and Violent Crime took action and secured Federal funds to study the problem. It followed that in 1998, the Wyoming legislature appropriated $3.2 million for the Wyoming Meth Initiative, a multiagency response to methamphetamine. Funds were allocated for improvements to the Department of Corrections, the Department of Family Services, the Attorney General's office and the Department of Health to enable them to respond to the demand brought by meth.

[1] Wyoming Methamphetamine Treatment Initiative. October 1998.

[2] New Bill Targets Methampehtamine, Enzi supports stronger penalties, preventative drug education. Feb. 25, 1999. http://enzi.senate.gov/meth.htm.

In 2000, the Substance Abuse Division was created within the Wyoming Department of Health to provide more resources necessary to increase treatment capacity and infrastructure to deal with meth. The Wyoming Substance Abuse Control Plan began laying the ground work for strategies to minimize substance abuse. Drug Courts expanded statewide. To date, 23 drug courts currently operate in Wyoming. Wyoming allocates more money per capita than any other State to drug courts.

In 2005, Wyoming legislators and State agencies continued to respond *enforce* by authorizing a study to review the scope of the meth problem and the efforts employed to address the problem. I assisted in this study which is amongst the first of its kind as it is a compilation of data collected by State and Federal entities and at the community level to quantify the problem of meth abuse in our State. The National Association of Model State Drug Laws currently uses Wyoming's Meth Study as a model of what States can accomplish with existing data-sets.

The Meth Study provided the beginnings of a road map which led to $9 million aimed at anti-meth efforts including funds to boost law enforcement, the court system, and treatment and prevention.

An integral component of Wyoming's statewide response to methamphetamine is prevention of gateway drugs including alcohol and nicotine. Wyoming high school students who reported smoking habitually were 8 times as likely to use meth during their lifetime compared to nonsmokers.[3] With this fact in mind, it follows that early prevention of nicotine and alcohol use is key to preventing later meth use. Multiyear prevention measures in Wyoming are working as both alcohol and nicotine are on a steady decline in our State as is meth use by our youth.

Building treatment capacity and maintaining a quality continuum of care is also key to Wyoming's response. SAMHSA reports that in Wyoming, residential treatment admissions for amphetamines increased by 1,440 percent between 1992 and 2004. We have made strides toward closing the treatment gap; however, a shortage of meth-specific treatment still exists in our State.

Wyomingites are keenly aware of methamphetamine in their State. Media coverage has been vital in getting the message out. Additionally, the Substance Abuse Division continues to mount our social marketing campaign against meth. Wyoming has not minimized talking about the problem. Instead, we have openly acknowledged the severity and have committed to action. Business owners are beginning to drug test. Community initiatives are taking action all across the State. Together we are rising to the challenge that the meth epidemic presents.

We have good news: Wyoming High School meth use decreased from 11.6 percent to 8.5 percent between 2003 and 2005. We must celebrate this success and use it to fuel us forward toward reducing the affects of the methamphetamine epidemic.

Question 2. How have you coordinated your efforts to address meth use and abuse with other public/private entities to improve the outcome?

A unique two-way partnership between Wyoming and the Federal Government has been instrumental in expanding our infrastructure to deal with the meth problem. In 1998, U.S. Senator Craig Thomas called for Federal resources to fund law enforcement at all levels and to assist in the Wyoming Methamphetamine Initiative.[4] [5] U.S. Senator Mike Enzi, in 1999, cosponsored an act to increase penalties for manufacturing and distributing meth and to fund law enforcement and prevention programs.[6] Wyoming Governor Geringer, while chair of the Western Governor's Association, agreed that States should create and maintain such partnerships with the Federal Government to seek solutions for meth associated problems such as lab cleanup. These key players with their ability to provide policy decisions fitting to Wyoming's unique rural nature, have been essential to our fight against methamphetamine.

Such key partnerships are occurring throughout the State including the Substance Abuse Division. The Division has worked in conjunction with lawmakers to establish the existing precursor legislation through House bill 293 which became effective in July 2005 placing restrictions on the sale and distribution of ephedrine and pseudoephredrine as well as established guidelines for retailers.

The Division works in conjunction with treatment providers to assist them in providing high quality of care for their clients. Certification is established according to Division standards and technical assistance has been offered. For example, the Divi-

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[3] 2003 Youth Risk Behavior Survey. Wyoming.

[4] Thomas Wins Assurance for Increase in Drug Enforcement. May 5, 1998. *http://thomas.senate.gov/html/pr97.html.*

[5] Thomas Seeks Federal Resources to Battle Drugs in Wyo: Innovative State/Federal Methamphetamine Strategy Offers Hope. Nov. 19, 1998. *http://thomas.senate.gov/html/pr136.html.*

[6] New Bill Targets Methamphetamine, Enzi supports stronger penalties, preventative drug education. Feb. 25, 1999. *http://enzi.senate.gov/meth.htm.*

sion coordinated the training of certified treatment providers in the Matrix System. The Division advertises treatment services available in specific regions through local media.

The Division serves as a contact to Federal, State and private agencies regarding the status of methamphetamine in Wyoming. At the Federal level, we have maintained a strong partnership with SAMHSA and have found their national and Wyoming specific data invaluable for preparing reports, trend measurement and providing direction for funding decisions. The Division is currently posed to follow SAMHSA's lead in modeling and reporting National Outcome Measures in our State.

The Division strives toward the goal of raising the awareness of the dangers of meth in Wyoming. With the assistance of our media contractor, we have developed a social marketing campaign specific to methamphetamine. In the near future, we will be collaborating with the Partnership for Drug Free America, which will be termed the Partnership for Drug Free Wyoming to bring new tv and radio media to Wyoming specific to methamphetamine.

Additionally, the Division has provided educational presentations and trainings to community initiatives, schools, teachers, emergency room personnel and other interested parties. In the future, we will continue to provide these trainings by proactively seeking educational engagements statewide.

Community initiatives are working all across Wyoming to draft protocols and procedures that are specific to their region. They are training up their community and seeking to end the meth problem. The Division acts as a primary point of contact for these initiatives. We are currently making efforts to connect these groups to each other to encourage them to share what works in each of their individual communities.

Senator ENZI. Dr. Rawson.

STATEMENT OF RICHARD A. RAWSON, PH.D., EXECUTIVE DIRECTOR, MATRIX CENTER AND MATRIX INSTITUTE ON ADDICTION AND DEPUTY DIRECTOR, UCLA ADDICTION MEDICINE SERVICES, LOS ANGELES, CA

Mr. RAWSON. Thank you, Senator. I appreciate the invitation to come to Casper.

I am hoping sometime I get invited during the summer, but I enjoy being here.

In California, methamphetamine has been the major drug problem we have had now for the last 15 years. In 1986, our organization was asked by the public health department in San Bernardino County to open an office to treat methamphetamine problems.

Since then we have treated about 11,000 meth users in our clinics in southern California and about 500 adolescent meth users. I think that's important. I think there is in some places a belief that adolescents don't use methamphetamine, and that's not the case.

As a result of that experience, we have collected a good deal of data. We understand how difficult methamphetamine users are to treat. We understand what methamphetamine does to their brains. We understand what the recovery looks like.

I have also been asked over the years to do talks around the country in many rural and suburban communities about methamphetamine, and one of the things I run into frequently is that many of the professionals in areas that have been impacted by methamphetamine have felt overwhelmed by the problem. They see many people coming in with severe medical and psychiatric problems. We're starting to get some handle on the fact that rates of hepatitis C among meth users on some populations are over 60 percent, particularly here in the mountain west. HIV rates are now starting to increase among meth users. It's a whole array of other problems. One of the things I hear in many of my visits in some

areas that treating meth users is not a useful endeavor, that they don't respond to treatment, and my main reason for being here today is to dispel that myth.

We have been working on treatment research now for over 20 years. We have collected some information. We had a large study funded in 1999 by the Center for Substance Abuse Treatment looking at a package of therapies we have developed called the Matrix model.

One of the sites of that—it was an eight-site study. One of the sites was in Billings, Montana, where we had a relatively large number of Native Americans, Hispanics and people from rural and the mountain west area.

In that study, we looked at treatment outcome. We followed it closely. We looked at the effect of treatment that showed improvement on reducing drug use, reducing criminality, reducing unemployment, showing improvements in other domains of people's lives. We followed up meth users at 6 and 12 months after admission.

The data suggested that somewhere in the neighborhood of 60 percent of them were doing well. These data are extremely similar to what we have seen with other substance abuse outcomes.

Now, we all know we can do better. We all want better tools. We all want higher success rates. But the myth that meth users do not respond to treatment is exactly that. It's a myth.

The treatment data are encouraging. Again, as I said, we need new tools. One of the areas that I think we have run into as being of greatest concern is we have some of these treatments with good efficacy, that show good results. However, it's hard to get the training done.

As was mentioned, the workforce issue was a big issue. Getting these treatment techniques out of the total field is a challenge. The Center for Substance Abuse Treatment has provided some help, but we need more help to get the treatment that works out to the communities.

Thank you.

Senator ENZI. Thank you.

[The prepared statement of Mr. Rawson follows:]

PREPARED STATEMENT OF RICHARD A. RAWSON, PH.D.

Senator Enzi and members of the committee, my name is Richard Rawson, I am a currently an Associate Professor in the School of Medicine at UCLA. I have worked in the field of drug abuse treatment and research for 31 years. Over that time I have studied and treated thousands of individuals addicted to heroin, cocaine, PCP, alcohol and other drugs. In 1986, the nonprofit treatment organization I helped establish, the Matrix Institute on Addictions, opened an outpatient clinic in San Bernardino County, California, at the request of the San Bernardino Health Department to address their already serious problems with methamphetamine dependence. In the subsequent 20 years, we have treated over 6,000 adult methamphetamine users in that clinic alone and another 5,000 adults in our network of four other clinics in southern California. In addition, during this time we have treated almost 400 adolescents admitted to treatment with diagnoses of methamphetamine abuse or dependence. I currently do a great deal of training on methamphetamine all over the United States and 2 weeks ago participated in a 2-day meeting at the United Nations Office of Drugs and Crime in Vienna on the extent and impact of methamphetamine problems around the world.

Over the past 20+ years, many small- and medium-sized communities I have visited have seen their criminal justice, social welfare and health systems overwhelmed by the problems presented by individuals addicted to methamphetamine. For many

of the professionals working in these settings, they were not ready for this influx of severely addicted meth addicts. Meth users frequently enter treatment with severe problems. They often are psychotic, paranoid and severely depressed. They have severe memory problems, difficulty making rational decisions and a very long lasting anhedonia, or inability to experience pleasure. They have many dental, medical, vocational, legal and family problems. Many are infected with Hepatitis C (here in the Mountain West that is a particularly serious problem) and increasing numbers are being infected with the HIV. We know their brains have been seriously impacted by the effects of methamphetamine on their neurobiology.

Many of the substance abuse treatment agencies that responded to the needs of these patients fell under siege. They weren't sure if these people should be put on psychiatric medication, put into psychiatric hospitals or long-term rehabilitation centers or treated with standard treatments for alcoholism and marijuana abuse. In many places, there was inadequate funding to provide enough treatment services to meet the needs of these patients and in virtually all places there was far too little training in effective treatment strategies. In some places and with some groups, this has led people to believe that treating meth users is a futile endeavor. One of my main goals here today is to dispel that misinformation.

During the past 15 years, at UCLA, my colleagues and I have conducted an extensive amount of research on many aspects of methamphetamine. We have conducted brain imaging studies, examining the impact of meth on the brain, we have explored the usefulness of almost a dozen medications for treating meth users, we are involved in studies on effects of prenatal exposure to meth and the impact of meth on drug endangered children and other issues. We have been especially interested in determining if meth addicts can be successfully treated and what treatments work best.

We have examined numerous strategies for treating meth users including cognitive behavioral therapy, contingency management and the Matrix Model package of outpatient strategies we adapted from the research literature. In the largest of these trials, one funded by the Center for Substance Abuse Treatment, we admitted over 1000 individuals into treatment in 8 clinic sites in the Western United States, including a site in Billings, Montana. This largest study conducted to date on meth treatment, as well as and several other studies we have conducted, provide strong support for the benefits provided by treatment when delivered by properly trained and funded treatment organizations.

Some specifics, we found in the CSAT-funded evaluation of the Matrix Model, that over half of the individuals we admitted were women, with a significant percentage of Hispanics, Asian Pacific Islanders and Native Americans. We found that with the proper treatment strategies we could engage and retain almost 60 percent of the individuals in outpatient treatment for over 8 weeks. During the time individuals were in treatment, over 85 percent of their urine tests were negative for methamphetamine and other drugs. During in-person follow up interviews at 6 and 12 months post admission, we collected urine samples under observation, and found that between 60 and 66 percent were meth-free and doing well in recovery (we were able to locate and interview over 80 percent of the study participants. In addition, we found very substantial reductions in marijuana and alcohol use, improvements in psychiatric status, improvements in family functioning, improvements in employment and decreases in criminal justice system involvement (arrest and incarceration). One particularly interesting finding was that our best treatment response came from the one site where the study was conducted in a drug court setting. These data and our experience at Matrix, where we run a drug court, suggest that drug courts are highly effective with meth users. We have conducted other studies evaluating some of the individual techniques within the Matrix Model, (cognitive behavioral therapy, relapse prevention and positive reward strategies) and we have published very encouraging results from these techniques as well.

All empirical evidence we have been able to collect, from research studies such as the ones I just referred to, as well as data from large State and county treatment systems suggests that properly trained and funded treatment programs can effectively provide treatment that works for meth users. We know recovering meth users need to be involved in treatment for an extended period to allow their brains to recover and for them to get their lives re-established. Properly funded and trained treatment programs can be extremely valuable community resources to help these individuals regain their ability to be useful and productive citizens. Treatment works and works well for people addicted to methamphetamine.

[The prepared statement of Ms. Gonzales and Mr. Rawson follows:]

PREPARED STATEMENT OF RACHEL GONZALES, MPH AND RICHARD RAWSON, PH.D.

METHAMPHETAMINE ADDICTION: DOES TREATMENT WORK?

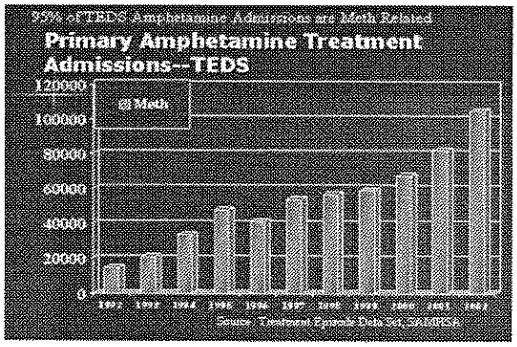
True or False

- 99 percent of first-time meth users are hooked after just the first try.
- Only 5 percent of meth addicts are able to kick it and stay away.
- From the first hit to the last breath, the life expectancy of a habitual meth user is only 5 years.

All three "facts" are false—Numbers 1 and 2 have never been studied and would be very difficult if not impossible to determine; number 3 is false. These "statistics" are cited on a Web site established by a State's Attorney General's Office. The statements are widely cited around the United States and in Canada as true statistics and have actually been used to argue against using money for apparently an almost hopeless task of treating meth users. The purpose of this article is to review what is currently known about the effectiveness of treatment for methamphetamine users.

Scope of the Methamphetamine Problem

Methamphetamine, known on the street by meth, speed, crystal, crank, and ice has emerged as the most dangerous home grown and one of the most widely used drugs in America. Much like heroin in the 1960s and 70s and the crack cocaine during 1980s and early 90s, the past decade has witnessed tremendous increases in methamphetamine (MA) misuse throughout much of the U.S. Worldwide, the United Nations Office of Drug Control estimates that over 42 million individuals regularly consume amphetamines around the world, more than any other illicit drug, except for cannabis. Domestically MA ranks as one of the most highly abused illicit drugs in urban and rural areas of the West, Midwest and South. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), national treatment admission rates for MA abuse increased by more than 420 percent for persons 12 years or older during the past decade (see figure below).

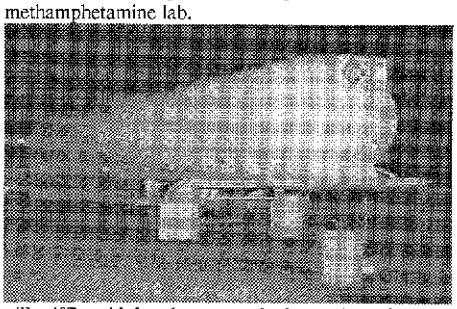


MA has not only expanded geographically across the Country, but also broadened demographically. Before the past decade, MA abuse was common among White males, with particularly extensive use among biker gangs and truck drivers. Currently, MA has become widely used by women, Latinos, gay and bisexual males, arrestees, and increasingly among adolescents. Although MA has historically been used via intranasal route of administration, in the past decade, smoking MA has become the dominant route of administration, although in some geographic regions over 50 percent of users inject the drug.

For the most part, the allure and abundance of MA can be attributed to its convenience. Like fast food chains, MA is widely available and inexpensive to purchase. Unlike most drugs that are imported from other countries, MA can be made by just about anyone in home "labs." Recipes and step by step instructions on how to make it are widely available on the Internet. The main ingredients, ephedrine and pseudoephedrine can be found in many over-the-counter cold and asthma medications available at most grocery and convenient stores. Items such as battery acid, hydrochloric acid, anhydrous ammonia, drain cleaner, rubbing alcohol, gasoline antifreeze, lantern fuel, and other cleaning products are among the other ingredients commonly used to make MA. MA labs can be built and set up inside homes, hotel

rooms, garages, and automobiles. Although, these home labs are a major public health and safety problem and are an important source of MA, the bulk of the MA is produced in large "superlabs" in California and Mexico, operated by major drug trafficking organizations. Restrictions on retail pseudoephedrine supplies may slow the MA production by home labs, but will have little, if any effect on the MA production by superlabs.

Meth Dealers Practicing Rocket Science

2 Kentucky Men Charged With Drug Trafficking *(June 2005)*	Anhydrous Ammonia Tank Tips Officers to Possible Meth Lab: *(May 2004)*
KINGDOM CITY, Mo. -- Troopers said two Kentucky men stopped on Interstate 70 in central Missouri planned to ditch two pounds of methamphetamine using a rocket in their car's trunk. The rocket stuffed with meth never launched. The men now face drug-trafficking charges. The patrol said two men of Louisville, Ky. and Sebree, Ky., were arrested Friday after a highway patrol trooper stopped them in Kingdom City. Officers said they discovered about $13,000 in the car and a large "hobby-style" rocket in the trunk. The rocket was attached to a system of ropes to pull it upright for launch from inside the car. It could be ignited by the car's cigarette lighter.	OMAHA, Neb. – Officials said that a large, 96 gallon anhydrous ammonia truck tank tipped off Sarpy County Sheriff's deputies to a suspected methamphetamine lab.  Sheriff's said that the owners had run a hose from the tank inside the house, which was a semi trailer parked in a residential neighborhood.

Physiology of Methamphetamine & Associated Health Effects

MA stimulates the central nervous system. The euphoria, "high" produced by MA use is directly linked to the release of dopamine. The high is especially immediate and powerful (the "rush" when the drug is smoked or injected). The powerful stimulant effects (i.e., increased energy, confidence, talkativeness, sex drive, decreased fatigue, and depression) last for 10–12 hours. Advances in brain imaging techniques have shown major abnormalities and deficits associated with MA use in certain parts of the brain that are responsible for feelings of pleasure, and other emotions, as well as memory and judgment. Despite these effects producing great impact on the functioning of users during recovery and the taking months to recover, it does appear that most are reversible.

The substantial health problems associated with MA addiction include severe weight loss, sleep disorders, damage to the cardiovascular system, stroke, as well as, severe dental and skin problems. MA use is a major factor in the spread of HIV in the gay community and has recently been shown to be highly associated with the spread of the hepatitis C virus.

Treatment for MA Addiction

The "only 5 percent" statistic stated at the beginning of this article is widely and frequently cited at national and regional meetings as evidence of the poor outcomes to be expected from treating MA users. A similar picture of dismal treatment outcome was presented in the January 23, 2003 issue of Rolling Stone Magazine story "Plague in the Heartland" where the statement "only 6 percent of MA freaks get and stay sober, the lowest number by far for any drug" was among one of the quotes attributed to the self-interested stakeholders such as local law enforcement. In some cases, these "statistical" statements are used to support the position that money spent on treatment is wasted and that the only fruitful investment is to reduce the availability of the drug through criminal justice, supply reduction approaches. An extensive literature search has failed to find any data to provide support for these statistics.

Medications: There are currently no medications with evidence to support their efficacy in treating MA intoxication, psychosis, withdrawal or dependence. NIDA has a very active program of research underway to test the safety of potential medications and examine their efficacy for treating MA-related disorders. Sites in Kan-

sas City, Des Moines, Honolulu, San Diego and Costa Mesa (California), coordinated by UCLA have tested several mediations and several other promising medications are planned for testing in the near future. In those circumstances when individuals with MA-induced psychosis present in emergency rooms or other health facilities, a common clinical practice is for physicians to use a combination of atypical antipsychotics and benzodiazepines to help calm the individual and prevent them from injuring themselves or others until the psychosis-inducing effects of MA have dissipated.

Psychosocial/Behavioral Treatments: Presently, there are two approaches that have evidence to support their efficacy for the treatment of MA dependence, but there is a much larger literature on treatments that work with the other major illicit stimulant problem in the United States, cocaine dependence. Although there are a number of differences in the pharmacology and physiological effects produced by MA and cocaine, these drugs have many common properties and similar effects. Research examining the treatment responses of MA and cocaine users suggests that cocaine and MA users have very similar outcomes when exposed to the same treatments. In addition, large scale treatment system evaluations have reported comparable outcomes for cocaine and MA users. To date, despite extensive examination of multiple data sources, no data have been found to support the frequently misused "statistics" mentioned above or the contention of poorer treatment outcomes with adult MA users.

Matrix Model: During the 1980s, the Matrix Institute on Addictions group in Southern California (including the present author, Rawson), created a multi-element treatment manual with funding support from NIDA, designed for application with stimulant users on an outpatient basis. The Matrix approach evolved over time, incorporating treatment elements with support from scientific evidence, including cognitive behavioral therapies (i.e., relapse prevention techniques), a positively reinforcing treatment context, many components of motivational interviewing, family involvement, accurate psychoeducational information, 12-step facilitation efforts, and regular urine testing. The approach is delivered using a combination of group and individual sessions delivered approximately three times per week over a 16 week period followed by a 36 week continuing care support group and 12 step program participation. Over 15,000 cocaine and MA users have been treated with this approach during the past 20 years. The manual and related materials have been published by Hazelden and SAMHSA. (For more details see www.Hazelden.org and www.SAMHSA.gov.)

In 1999, CSAT funded a large scale evaluation of the Matrix Model for the treatment of MA users coordinated by UCLA. Roughly 1,000 MA dependent individuals were admitted into 8 different treatment study sites. In each of the 8 sites, 50 percent of the participants were assigned to either Matrix treatment or to a "treatment as usual" (TAU) condition, which was comprised of a variety of counseling techniques idiosyncratic to each site. The study result showed that individuals assigned to treatment in the Matrix approach received substantially more treatment services, were retained in treatment longer, gave more MA-negative urine samples during treatment and completed treatment at a higher rate than those in the TAU condition. These in-treatment data suggested a superior response to the Matrix approach. When data at discharge and follow up were examined, it appeared that both treatment conditions produced comparable post-treatment outcomes. Participants in both conditions showed very significant reductions in MA use, significant improvements in psychosocial functioning, and substantial reductions in psychological symptoms, including depression. Follow up data indicated that over 60 percent of both treatment groups reported no MA use and gave urine samples that tested negative for MA (and cocaine) use. Use of other drugs, such as alcohol and marijuana were also significantly reduced.

A particularly interesting finding was that across the 8 treatment sites, the "drug court site," e.g., the one that enrolled individuals who were participating under a drug court program, produced superior results compared to the other 7 sites, suggesting a substantial beneficial influence of drug court involvement. Overall, this evaluation is the largest controlled study of MA treatments that has yet to be conducted.

Contingency Management (CM): Positive reinforcement is a powerful tool in increasing desired behaviors. School teachers who have given "special prizes" for superior performance, companies who give employee incentive bonuses for meeting production goals, AA meetings that give "chips" and cakes to acknowledge successful progress in achieving sobriety are all examples of the effective use of positive reinforcement. Many existing treatment programs informally use positive reinforcement as part of their treatment milieu. Frequently, the reinforcement takes the form of verbal praise, or earning program privileges, or "graduating" to a higher level of sta-

tus in the program or some other practice to acknowledge and reward progress in treatment. CM is simply the systematic application of these same reinforcement principles. In many of the studies investigating CM approaches, treatment participants can earn "vouchers" that are exchangeable for non-monetary desired items (e.g., free movie tickets, restaurant dinners, grocery vouchers, gasoline coupons, etc.). Typically the individual can earn larger valued rewards for longer periods of continuous abstinence from drugs and alcohol.

Over the past 30 years, a number of researchers and research groups at Johns Hopkins (Stitzer, Silverman), Vermont (Higgins and colleagues), Connecticut (Petry and colleagues), and UCLA (Roll and colleagues) have demonstrated the powerful effect of CM techniques to reduce heroin, benzodiazepine, cocaine and nicotine use. Recently CM techniques have been implemented with MA users in Southern California by the group at UCLA and by researchers in the NIDA Clinical Trials Network. The results of these investigations have provided powerful support to the efficacy of this behavioral strategy as treatment for MA abuse. Individuals who have been assigned to CM conditions have shown better retention in treatment, lower rates of MA use and longer periods of sustained abstinence over the course of their treatment experience. Without question, CM is a powerful technique that can play an extremely valuable role in improving the treatment response of MA-dependent individuals.

Response to treatment: Cocaine vs. Methamphetamine

To date, the majority of studies investigating the effectiveness of treatment for stimulant addiction have focused on cocaine abuse with fewer studies on MA. Despite differences between the two stimulants in individual health, psychological and cognitive effects, both groups tend to show comparable responses to psychosocial behavioral treatments. In one large study using the Matrix Model, 500 MA dependent individuals were treated alongside 250 cocaine dependent individuals at the same clinic, by the same staff, over the same time period, using the same approach. Treatment outcomes were identical both during treatment and at follow up. Similar findings have been reported from treatment studies in San Francisco and from data collected in Los Angeles County and throughout California. While there is absolutely no evidence that MA users and other drug user populations respond differently to treatment, there are multiple controlled and large scale treatment outcome studies that suggest that treatment outcomes for MA and cocaine users is very comparable. Taken together, these results tend to dispel the false beliefs about treatment effectiveness for MA addiction circulating within the public sphere.

Implications for MA Addiction Treatment: Psychosis, Route of Administration, Sex, Infectious Diseases, Women and Kids

Much of the ambivalence about MA treatment effectiveness stems from sentiments that "meth abusers are difficult to treat," quoted by many in the field and press. Studies have identified unique characteristics of MA abusers that may pose many clinical challenges that are frequently more problematic than is seen with standard treatment populations. MA abusers come to treatment with unique demographic and health profiles. For instance, MA abusers have been consistently observed to experience severe psychiatric problems, including psychoses, hallucinations, suicidal ideation, and severe depression and cognitive impairments when presenting for treatment. At present, it is not clear how much of the psychiatric symptomatology is directly related to the effects of the drug and what role co-morbid disorders are involved. Clearly, however, clinicians treating MA have to be educated about working with patients who have clinically significant levels of disordered thinking and persisting paranoia.

Historically, MA use has been via intranasal and injection routes of administration. However, in the past decade, smoking has become the dominant route of MA administration, and more recently some geographic areas (e.g., South Dakota, Oregon) have reported elevated rates of MA injection. Smoking and particularly injecting MA appears to lead to a more difficult addiction to address. Injection users tend to report far more severe craving during their recovery and they have higher rates of depression and other psychological symptoms before, during and after treatment. They also have higher drop out rates and exhibit higher rates of MA during treatment. In addition, recent reports have documented the extremely powerful relationship between MA use and sexual behavior. Individuals who use MA describe a far more powerful association between MA and sexual behavior than cocaine, heroin or alcohol users. Issues around sexual readjustment during sobriety are very important and can play a very big role in relapse, if not properly addressed.

In a recent sample of MA users who entered treatment in the Midwest, Hawaii and California, the rate of Hepatitis C infection was 22 percent. Of the MA

injectors, over 70 percent tested positive for hepatitis C (Hep C). Clearly, there needs to be a strong message about behaviors that expose individuals to Hep C infection (blood to blood transfers) in treatment and prevention efforts. In addition, MA use is associated with very high risk sex and has been shown to be a huge factor in HIV transmission among gay men. Research by Shoptaw, Reback and colleagues in Los Angeles has shown that MA use is the biggest threat in the gay community to producing a renewed spread of HIV. They have developed treatment materials for this group and have shown that successful treatment of MA dependence is an extremely effective HIV prevention strategy.

Women use MA at rates equal to men. Use of other major illicit drugs is characterized by ratios of 3:1 men to women (heroin) or 2:1 (cocaine), in many large data sets, the ration for MA users approaches 1:1. Surveys among women suggest that they are more likely than men to be attracted to MA for weight loss and to control symptoms of depression. Among women, MA abuse may present different challenges to their health, may progress differently, and may require different treatment approaches. Over 70 percent of MA dependent women report histories of physical and sexual abuse, as well as more likely than men to present for treatment with greater psychological distress than males. Many women with young children do not seek treatment or drop out early due to the pervasive fear of not being able to take care of or keep their children as well as fear of punishment from authorities in the larger community. Consequently, women may require treatment that both identifies her specific needs and responds to them.

These unique clinical symptoms commonly experienced among MA abusers suggest that effective treatment of MA abusers should be comprehensive, including greater emphasis on infectious disease transmission and other psychosocial issues. While these differences highlight the importance of developing more effective treatment models for MA addiction, studies have shown that treatment response using similar treatments is highly comparable between MA users and cocaine users. Thus, it can be argued that it is not necessary to design completely new approaches for MA addiction. Rather, focus should be targeted at enhancing existing treatment regimens with supplemental type services that address these underlying differences among the MA patient.

Future Directions

This paper offers useful information and opportunities for clinicians, policymakers and treatment providers to effectively treat challenging populations characterized by MA addiction. Future outcome based studies on the long-term clinical aspects of MA addiction are needed to provide a comprehensive overview of MA addiction after treatment. Currently, a 3-year follow up study on treatment outcomes among a subsample of MA abusers who participated in the large Matrix Model clinical trial is underway. This study will not only speak to the question concerning the long-term effectiveness of MA treatment, but will also highlight the effects of treatment on addressing the clinical issues present among MA abusers overtime.

Overall, examining what we currently know about MA addiction and treatment not only debunk the erroneous "statistical" statements that indicate MA abusers are not treatable, but also highlight special issues concerning clinical ramifications associated with MA abuse and treatment which may serve to challenge the frontline professionals working to confront the growing problem of MA addiction.

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Senator ENZI. Sergeant Hamilton.

STATEMENT OF STEVE HAMILTON, CAMPBELL COUNTY SHERIFF'S DEPARTMENT, GILLETTE, WY

Mr. HAMILTON. Thank you, Senator.

Senator, my agency, the Campbell County Sheriff's Office, has been involved in methamphetamine investigations for several years.

I became a reserve officer with the Campbell County Sheriff's Office in 1978, and my first duty was to investigate a methamphetamine user and complete a search warrant in 1978.

Methamphetamine began to wane through the early 1980s and came back with a vengeance in the 1990s.

In my capacity, I have worked as a deep undercover officer, supervisor of narcotics unit, supervisor of patrol units, and I believe for our area I have a very strong, substantial understanding of the methamphetamine problem.

In the mid-1990s, I was approached with a question as to why inmates were losing teeth, and that was associated with people arrested for methamphetamine.

From that curiosity, I began to study the medical aspect and treatment aspects of methamphetamine and then joined with my current partner, Quentin Reynolds, who is the supervisor of the DARE and resource office—officers in the Campbell County Sheriff's Office.

We developed a methamphetamine awareness program and began presenting it within the area of Campbell County and the other four counties that surround us, Weston, Crook, Sheridan and Johnson County.

Within our studies, within our activities that have brought us in direct contact with methamphetamine abusers and the problems of methamphetamine, we believe that the most important aspect of methamphetamine is the availability or, unfortunately, the lack of availability to treatment; that the treatment effort is the No. 1 answer to this problem. While we in law enforcement believe that enforcement is also a part of that, we shouldn't be limited to putting the word "law" in front of enforcement. Family enforcement, school enforcement, labor enforcement, community enforcement, peer enforcement all has to play into controlling this methamphetamine problem.

Also, that treatment has to be available to all those different areas of enforcement. Families have to have access to, when they provide enforcement, access to treatment, businesses, schools, not just law enforcement, not just the jails.

The other thing we warn in our talks is that while we support and agree with legislation, statutes and control of meth-related problems such as labs, precursors and these types of legal statutes, the problem is the market. The problem is the user and the answer is the treatment of the user.

The reason meth was there in 1978, waned and came back in 1992 was in 1980, Federal legislation controlled phenyl-2-propanone, P2P, a chemical used to make methamphetamine. When the new ephedrine-based recipes came out, it came back with a vengeance.

If we legislate only and solely toward control of labs and chemicals and leave the market in place, if we do control that chemical,

right over the horizon is the family of phentanyls which will be a vengeance upon our society worse than methamphetamine ever was.

We need to promote treatment and promote good treatment and start our treatment as any medical system would work in a proper triage. Not waiting until a user is so addicted and is such a criminal that treatment centers have to deal with an almost overwhelming addiction. We have to start treatment at a misdemeanor for the State of Wyoming, a misdemeanor level or a new user level where treatment is effective, triage, work, applied treatment where it's going to be effective, not waiting.

Unsupervised probation, plea bargains are the bane of this problem.

Thank you, Senator.

Senator ENZI. Thank you.

[The prepared statement of Mr. Hamilton follows:]

PREPARED STATEMENT OF STEVE HAMILTON

SUMMARY

My answers to the two questions which will form the basis of the discussion are documented completely within the first two pages of my submission. My recommendations to the Senate Committee on Health, Education, Labor, and Pensions, are enclosed at the end of my submission under the heading, "FEDERAL LEGISLATION." The remainder of the submission supports my recommendations.

Cpl. Quentin Reynolds, the Campbell County Sheriff's Department D.A.R.E and School Resource Officer Supervisor and I have developed a 2½-hour presentation, Methamphetamine Awareness, that we have shared with parents, teachers and professionals in the five county regions of Wyoming (Campbell, Crook, Johnson, Sheridan and Weston Counties). Cpl. Reynolds and I both work as full time law enforcement officers in assignments targeting controlled substance violations. From our duty assignments, we have developed a great deal of experience, but it is the Methamphetamine Awareness Lectures that have given us a clear understanding of the methamphetamine problems which exist in the rural communities. The lectures have given me the opportunity to successfully share the concerns of both the public and private entities with the Campbell County Coalition Promoting a Drug-Free Community, which my wife, Diane, and I belong to. The information from the lectures and the coalition meetings have given me the ability to assist in a coordinated response to the problem. The lectures have also provided Cpl. Reynolds with the same broad understanding of the communities' methamphetamine concerns. Cpl. Reynolds works within the school districts of our area to assist in coordinating school concerns and efforts with solutions involving other entities.

While the requested written submission addresses the immediate concern, methamphetamine use in rural areas, what we have learned from our lectures, and share in this written submission can be applied to any community, rural or urban. The submission identifies the problems arising from methamphetamine abuse and provides solutions.

The solutions are easy to describe, but it will be difficult to implement. Enforcement efforts directed toward the market of addicted users must be improved. Enforcement should be directed at new and short-term users to make treatment dollars effective. Enforcement responsibility must include family, school, employer, community, and not limited to law enforcement. Wherever enforcement occurs, there must be a realistic treatment available. Any legislation directed toward a specific chemical precursor, while warranted, is ultimately doomed to fail.

During the last 3 years, Cpl. Quentin Reynolds and I have given Methamphetamine Awareness Lectures within the community. Beginning in 2006, we have been joined by treatment counselor Frank "Joe" Zigmund of Personal Frontiers, a nonprofit addiction counseling center in Gillette, Wyoming. At the end of each lecture, we explain that the methamphetamine problem needs to be confronted in the same way drunken driving, child abuse, domestic violence and racism have been confronted and diminished—by strong public opinion. Individual concerns need to be presented directly to those in charge of the community's budget and the community's legal voice.

Quentin and I have law enforcement responsibilities, but there are also family members who worry about rising health care costs and are concerned about safe work environments. They want children to have opportunity, not adversity. In the past, law enforcement has tried to present the entire community's drug-related concerns and solutions. A far more accurate and realistic approach is the formation of the coalition to share concerns with the public and the government.

Quentin and I have tried to eliminate all exaggeration from our lectures. We believe our children are Campbell County's future. Each group we have spoken with has both individual and shared concerns and solutions. The community's "all for one and one for all" feelings are apparent. We hear individual problems, but we are also asked about treatment, children, and the future. The more we learn about physical health problems, mental health problems and treatment problems associated with methamphetamine, the more we realize we need everyone's involvement to allow those children to create a drug-free future.

During the last 2 years our Methamphetamine Awareness presentation has reached the following:

- All Secondary Education teachers in Campbell County (four presentations)
- A majority of the Primary Education teachers and bus drivers in Campbell County
- Secondary Education teachers in Sundance, WY
- Secondary Education teachers in Moorcroft, WY
- Secondary Education teachers in Newcastle, WY
- School teachers and general community in Dayton and Big Horn,
- WY School teachers in Clearmont, WY
- School teachers and general community in Upton, WY
- School teachers in Hulett, WY
- Community of Sheridan, WY
- Community of Gillette, WY (two presentations)
- Community of Newcastle, WY
- Community of Clearmont, WY
- Presentations to four Gillette, WY Churches
- Wyoming Chaplains training in Wyoming Law Enforcement Academy
- Presentations to four businesses in Gillette, WY
- Methamphetamine Conference in Buffalo, WY
- Department of Family Services, Gillette, WY
- Presentations to foster care families (two presentations)
- Campbell County Children's Center
- Campbell County Public Health Office
- Campbell County Commissioners
- Gillette City Council
- Gillette Abuse and Refuge Foundation
- Volunteers of America
- DCI Basic School (recognized as Police Officer's Standards and Training credit)
- State D.A.R.E. Conference
- Wyoming Girl's School at Sheridan, WY
- Campbell County Memorial Hospital (two presentations recognized as health care training credit)
- Three presentations to Gillette, WY dental offices
- Gillette Optometric Clinic, WY
- Emergency Medical Technicians College
- Surface Mine Emergency Response Teams (three presentations)
- Personal Frontiers Inc.—Counseling Service, Gillette, WY

The most important result of our presentation is that we have heard the concerns expressed from such a broad field of private and public entities. During our presentations we have shared honest, realistic and factually correct methamphetamine information with more than 2,000 people in our rural communities. During the week of October 23, 2005, the Coalition Promoting a Drug-Free Community of Gillette, Wyoming published a 24-page supplement to the local newspaper, *The NewsRecord*. The supplement, Celebrating Red Ribbon Week, a National Anti-Drug Awareness Campaign, provided the readers with a great deal of information and invited readers to attend a presentation by Mary Haydal of Miles City, Montana. Mary Haydal had lost her 19-year-old daughter to a methamphetamine overdose. Three pages of this supplement, Celebrating Red Ribbon Week, contained information that Cpl. Reynolds and I had learned. This submission contains parts of that article.

The following paragraphs describe what Quentin and I have learned from the Methamphetamine Awareness Lectures. While, within the information I refer only

to northeast Wyoming, these same concerns arise anywhere there is a market of methamphetamine abusers.

SCHOOLS

In 2002 the Federal methamphetamine trafficking investigation known as Harbour et al. identified an 18-year-old Gillette female methamphetamine dealer with 85 customers, mostly her peers. The investigation resulted in the arrest and conviction of all the "big dealers." The market remained in place. Three years ago, the Campbell County School District witnessed a methamphetamine dealer declare that she used 10 "runners" to move $35,000 of methamphetamine each week to her primary market—high school students. The "big dealer" was convicted. The market was left in place. The Federal trafficking investigation of the Allen's family resulted in the identification, arrest and convictions of a trafficking system that brought pounds of methamphetamine into Gillette, Wyoming. The primary suspects, the Allens, used their 14-year-old and 18-year-old sons to distribute methamphetamine to their peers. The market was left in place.

Elementary School teachers and counselors watch an increasing population of ADHD students that are associated with guardians who are suspected of methamphetamine use. Junior High Schools are locked between the increasing ADHD population approaching from the Elementary level and the decreasing age of drug abusers from above.

Counselors are required by Wyoming law (WSS 14-3-205) to report suspected child abuse and neglect. A local defense attorney challenged this, receiving an opportunity to question the counselor's professionalism in District Court. The counselor's decision was upheld, but this style of intimidation needs to be addressed. The attorney had the legal right to question the law. The court had the duty to consider the attorney's question, but school counselors being victimized in this way is an important, real and political event. Public support of the schools, the administrators, the teachers and the counselors must be expressed.

CHILDREN

The Campbell County Public Health Office and the Campbell County Children's Development Services witness the devastating effect upon child victims that a guardian's use of methamphetamine produces.

The Wyoming Department of Family Services of Gillette attributes a huge percentage of their neglect reports to guardians using methamphetamine or allowing methamphetamine into the home. DFS is a Wyoming State agency, but the local agents are an exceptional source of information about Campbell County conditions. Foster care has reached a critical shortage. The Youth Emergency Services House (Y.E.S. House) has continuous contact with youthful victims of methamphetamine, and needs greater community support. Childcare facilities and foster families can be a budget consideration for our tax dollars.

MEDICAL

The OB/GYN staff of the Campbell County Memorial Hospital has watched methamphetamine devastate the lives of newborn infants and this inflicts a huge financial burden on health care costs. The Emergency Room staff witnesses a continuous flow of patients receiving medical care for illnesses that would be nonexistent except for methamphetamine.

The Campbell County methamphetamine market has charged the community for emergency room visits, prenatal and postnatal childcare, neglected and abused childcare, dental care, County Health provision, inmate health care, labor accidents, and domestic violence injuries. Dental offices have seen a continual increase in methamphetamine-related gum disease and tooth decay. It is irrelevant if these unnecessary medical expenses are being paid by insurance (overall rates then, of course, increase) or left unpaid by the patient. We are ultimately paying.

The continuous "in your face" devastation methamphetamine has created to children confronts nurses and doctors, as it has teachers and counselors. These professions are difficult enough without the added helplessness of seeing guardians continue to use methamphetamine with impunity. This information needed to be directly and frequently stated to the controllers of Campbell County's budget and legal voice. It is not the information protected by patient's rights that is important; it is the whole picture, the number of patients and the number of health care dollars lost.

LABOR

Real and powerful concern has been expressed by every organization—governmental and private. Diverse groups, such as the local Drug Free Workplace Committee, have sought realistic solutions to the damage methamphetamine has inflicted on Campbell County. Responsible local businesses have entered into investigating ways to identify drug users within their workforce and to understand every option in dealing with individual abusers.

Private drug testing facilities have been very supportive in their attempts to improve the reliability of chemical testing. Their recommendations to Campbell County businesses are realistic. The testing facility documents the contents of the sample, but improving the collection techniques and varying the testing methods, both responsibilities of the client can dramatically improve the accuracy of the test. Responsible employers now realize the samples are easy to manipulate by individual employees and unscrupulous businesses to provide false negative results.

Honest business, in an effort to provide a safe work environment, has become the victim of both employee methamphetamine use and dishonest business practices by a few manipulative companies. Honest business must continue to keep methamphetamine out of the workforce, and will be confronted with the cost of such efforts. Too often, where no problem is routinely found, efforts wane and the cost of eradicating methamphetamine from a workforce becomes far greater.

TREATMENT

Methamphetamine treatment is not isolated to the relationship between an addicted abuser and a counselor. Treatment is a consideration to employers, DFS, the Y.E.S. house, school counselors, The Campbell County Drug Court, the Diversion Program, Probation and Parole departments, and the strong recommendation by private physicians to addicted patients.

Treatment needs to start with new users, where treatment has a reasonable possibility of success. Too often health care costs are wasted on abusers that are seriously addicted. Our limited resources should be invested where failure is minimal and a high expectation of recovery.

Treatment for tobacco abuse in juveniles is minimal, but nicotine has been identified as a very probable physical gateway drug, acting on the brain in a similar way as methamphetamine. Effort to minimize teenage smoking is not just a long-term cancer and respiratory defense. The probable association of nicotine and methamphetamine needs to be clearly stated.

CITIZENS GROUPS AND FAMILIES

The Campbell County Coalition for a Drug-Free Community has a strong base of support in the Gillette. The Coalition was formed to confront all drug use, including tobacco and alcohol. The members are interested in increasing awareness of drug issues, enforcement of laws, and treatment of victims.

Every person has family interests, but those family members who attend lectures given to church groups, foster parent groups and the general public learn more ways to protect their family. Many, already have suffered a loss. This loss, if they were comfortable sharing it with a Commissioner or member of the City Council would have a great impact.

Conventional families rarely exist in the methamphetamine culture. Children are raised and "guarded" by stepparents, boyfriends, girlfriends, significant-others, their siblings, methamphetamine customers, methamphetamine dealers, or just anyone that is convenient while the original parent is "hooking up."

LEGAL ISSUES

Place one of the most addictive drugs in one hand of a young person, and unsupervised probation into the other. Which will win? Strong, productive, informed sentencing argument is the responsibility of the County Attorney.

The error of placing first time methamphetamine offenders on unsupervised probation needs to be explained by professional treatment counselors not law enforcement. Treatment counselors, treatment hours, and treatment dollars are best spent when first time users are sentenced to extensive treatment. Professional testimony is needed to help courts use these extremely limited resources in the most beneficial manner.

If the Campbell County Attorney is being forced by the lack of foster care or professional testimony to a plea bargain with criminals that endanger children, these needs should be addressed. The crime of placing a child in an environment of methamphetamine abuse, identified not only by the drug and paraphernalia, but by a

guardian's lifestyle has been successfully presented to courts in States considered liberal by Campbell County standards. This crime can be successfully prosecuted in Campbell County.

LAW ENFORCEMENT

The community's law enforcement agencies are, like the medical professionals, teachers, businesses, treatment professionals and family members, limited to the scope of their authority and jurisdiction. The Campbell County Detention Center's inmate health care costs are tremendous. Drug-related family violence, child abuse, and thefts are the majority of law enforcement's call load.

Law enforcement needs the entire legitimate community to understand methamphetamine will continue to thrive where a market exists. Local law enforcement has absolutely no jurisdiction at the sources of methamphetamine. Past legal actions have been most often directed at methamphetamine dealers moving the drug from the out-of-state source to the Campbell County methamphetamine market. Leaving the source and the market in place has substantially helped to create the problem we all face.

During our Methamphetamine Awareness presentation, the audience is confronted with an analogy. In the recent past, two supermarkets in Gillette, Wyoming, closed for a brief period. This reduced the "big dealers" of food by 50 percent in our community. With half of the "big dealers" gone, not a single person quit eating, not a single family left town. If (from possibly a natural disaster) the remaining two supermarkets would have been destroyed, the audience agrees that still no one would quit eating, and Gillette would remain a stable community until the "big dealers" were up and running. Methamphetamine sales are identical. When a "big dealer" is shut down, users do not quit or leave. The methamphetamine user may use a street dealer of drugs for a source, travel out of town for purchases or even try to manufacture methamphetamine. Abstinence will not occur and the reality of the drug culture guarantees that another "big dealer" will arise, possibly within hours. Leaving a market of addicted users is the result of trying to appease public demands for the enforcement dollars to be spent identifying and arresting "big dealers." This type of political pressure leaves local law enforcement officials, with limited jurisdictional power, to minimize their efforts toward reducing the market, while using their limited manpower in support of task forces which can create newsworthy statistics.

The Wyoming Division of Criminal Investigation (DCI) has been exceptionally successful at targeting methamphetamine traffickers. DCI has both the statewide jurisdiction and public support to go after "the big dealer." Campbell County's local law enforcement needs equally strong public support to reduce the local market, the users. Campbell County law enforcement must work within their jurisdiction, and cannot force other States to increase their enforcement efforts to eradicate the ultimate source.

METHAMPHETAMINE ADDICTED USERS

The Drug Court, treatment centers, the Campbell County Detention Center and Volunteers of America routinely have patients, inmates or clients that have information pertinent to the overall knowledge of anyone truly trying to understand methamphetamine abuse. I have spoken with more than a thousand of these folks over 25 years. Many, while telling me arrest is not the answer, have admitted it was only arrest that moved them to change. I have never heard of a new user seeking treatment. Heavy abusers that no longer are receiving pleasure from a drug they have built a tolerance to, may seek treatment. Unfortunately, when tolerance diminishes, the vast majority (probably 85 percent) return to methamphetamine. They want to be clean, and they, better than anyone, understand what they have lost, but this drug overrides the best intentions and the finest treatment. Employees that have been confronted with a possible loss of a job, may seek treatment. The person we are trying to save, a young, new user of methamphetamine, will not volunteer for treatment.

I strongly disagree with a statement I frequently hear, "You can't arrest your way out of this problem." What you cannot do is "incarcerate your way out of this problem." There are not enough cells to hold the entire Campbell County's methamphetamine market. We can arrest our way out of the problem. Not just conventional arrest, but employers enforcing their anti-drug policies, schools enforcing anti-drug policies, parents not turning a blind-eye to children's use. As users are arrested or confronted, treatment cannot be the option; incarceration may be an option, expulsion may be an option, job termination may be an option, grounding may be an option, but treatment must be mandatory. These facilities do not currently exist, but

tax dollars can be used to increase availability. Sentencing can be used to maximize group counseling of new offenders on weekends instead of ludicrous unsupervised probation.

THE COMMUNITY

The individual citizens groups, professions, businesses, public offices and families need to focus together on the most cost-effective and law-effective ways to coordinate all the knowledge within Campbell County, Wyoming, against methamphetamine abuse. During the last 3 years, Quentin and I have realized that our community contains an incredible wealth of knowledgeable and capable citizens that are already confronting issues of methamphetamine abuse. The community does not need to seek or employ experts from outside, or fund independent studies. We, as a community, simply need to coordinate our efforts.

FEDERAL LEGISLATION

Effective Federal legislation will not waste tax dollars on the creation, implementation and enforcement of new criminal statutes. Current statutes adequately support the investigation of interstate trafficking systems.

Current Federal law supports prosecution of interstate criminal activity and is an effective use of resources. Trafficking in any controlled substance is usually an example of a criminal activity that creates far-reaching conspiracies that exceed the jurisdiction of local law enforcement. When the illicit manufacture of methamphetamine becomes the object of the investigation, the interstate transportation of large quantities of pseudoephedrine would, under current laws, be an element of conspiracy and give venue to a Federal enforcement agency. Activities that are isolated to a small methamphetamine market, "mom and pop" methamphetamine laboratory, or family use which endangers children should be handled by local law enforcement using State or local statutes. It can always be argued that any illicit drug use arose from a larger conspiracy, but this is not always the case with methamphetamine. The abused drug can be produced from legally purchased products and then "cooked" in a local laboratory.

Federal legislation should not consider entering into the current legal philosophy of controlling pseudoephedrine sales. I am not opposed to these laws on a State and local level. Any large "super lab" will not be purchasing blister packs of retail pseudoephedrine, and the current Federal conspiracy laws can be successfully used to deal with large shipments of wholesale tablets designated for illicit production of interstate quantities of methamphetamine.

Federal statutes attempted to control the production of methamphetamine by making the chemical Phenyl-2-Propanone (P2P) a schedule II substance on February 11, 1980. Attempting to control any drug use by "arresting" a chemical instead of dealing directly with human activity is doomed to failure. The market was left in place, and after a short period of time a new formula, eliminating the need for P2P was not only made available, but ironically created the current situation of a far easier production method. In the Spring of 2005, I contacted Wyoming State Representative Thomas Lubnau, and in a letter warned him that laws controlling the sale of pseudoephedrine, while proper, were not going to result in effective control of the methamphetamine problem. On July 28, 2005, Iowa Congressman Tom Latham released a newsletter announcing his plans to introduce a bill "that would make Iowa's tough restrictions on the sale of pseudoephedrine" a Federal law. On January 23, 2006, Kate Zernike of The New York Times published an article, *Potent Mexican Meth Floods in as States Curb Domestic Variety*. Within the article, Betty Oldenkamp, secretary of human services in South Dakota, said, "You can't legislate away demand." The failure of Iowa's anti-pseudoephedrine law is discussed. The most important statement within the article is, "But here and in many of the States with recent pseudoephedrine restrictions, frustrations with the stubborn rate of addiction has moved discussions from enforcement to treatment and demand reduction." Just over the horizon is a family of chemicals, the Fentanyls. Chasing and "arresting" chemicals will simply move users to a new drug if the manufacture of methamphetamine is reduced while the demand remains.

Further proof that "arresting" a chemical is doomed to failure, requires only a look at the 18th Amendment. Alcohol was the chemical, and while trafficking and production was confronted, the market was left in place.

Federal methamphetamine law, particularly from the Committee on Health, Education, Labor, and Pensions, can be effective. Providing a system that requires treatment assessment and effective probation attached to sentencing of convicted methamphetamine users will make a difference. If real and effective treatment can also be mandated, the positive effect will be even greater.

The most important response the Federal Government could make to address the growing methamphetamine problem is the development of an addiction evaluation program supported by follow-up counseling and treatment, complete with a mandatory payment plan that would be available as a sentencing option for local and State courts.

This is not a "pay-me-now or pay-me-later" situation. The price of methamphetamine addiction currently placed on innocent taxpayers is beyond accurate determination. Methamphetamine is a situation of "you're-paying-me-now and you're-going-to-pay-me-more-later." The development of good, responsible counselors and probation officers will be difficult, but this is an investment in the future. When, through proper treatment the methamphetamine market begins to diminish, any system of counselors and probations officers can be used productively to confront other addictive behaviors that are currently threatening society.

Treatment and probation of addicted users are not a system of socialized medicine. Reimbursement would be a mandatory return for the user. The cost of effective treatment is great, but it is approximately the same as the cost of a mid-level vehicle, and far less than a home. Taxpayers are expected to pay for their needs and methamphetamine users can be equally responsible when proper local enforcement is applied. Proper local enforcement is methamphetamine investigation and intervention at new-user levels. Beginning users have a reduced addiction making treatment more cost effective. New users are frequently of an age that, on an average, family responsibilities are minimal, and responsible treatment will provide an opportunity for the user to enter the workforce. Timely and effective counseling increase the probability the user will become a productive member of society. Currently law enforcement politically supports the public misconception that investigating new users is a waste of tax dollars. This misconception even invades prosecutorial decisions and judicial sentencing. In Campbell County, Wyoming, the normal response by the judicial system is to accept a plea agreement that reduces methamphetamine possession charges to simple use. Sentencing results in a minimum fine and placement of the offender on unsupervised probation. Judges, prosecutors and the public want to wait until the offender has created such an addiction that the offender has begun sales to support his/her habit. Unfortunately reasonable treatment cost, then exceeds any possible payment source.

The legal term of felony or misdemeanor is moot. Plea bargains are the bane of successful treatment, success for the addict or safety to the community. First time offenders should receive a short incarceration to allow them to minimize the mental interference of methamphetamine use, and then see a counselor for the determination of an addiction evaluation. Reasonable outpatient treatment should be supplied if appropriate and a close association with a probation system maintained to minimize destructive behavior. Second offenders, when, appropriate, should receive a minimum of 60 days incarceration to give counselors a chance.

Employers that are provided with the support of mandatory treatment and probation of errant employees may see it financially suitable to retain a trained but addicted person. Families that recognize a local government will provide evaluation, counseling and probationary control on juvenile offenders will be far more accepting of user-level enforcement. Mandatory return to school should be part of any juvenile offender's probation.

Research and development of drug testing systems that are more accurate and more difficult to manipulate will also support probation officers, employers and families.

The only criminal legislation that would be supportive of the treatment/probation program would address counselors, probation officers or testing facility personnel that violate their responsibilities.

This type of legislation was introduced by Wyoming Representative Thomas Lubnau to the Wyoming House Judicial Committee in February 2006. It passed quickly and moved to the House where it was also passed. In the Wyoming Senate Judicial Committee it was stopped. Federal support of this same program would have a nationwide positive result. States, or cities choosing to recklessly allow the use of federally controlled substances, such as marijuana, have obviously taken a path that Federal treatment support does not need to tread upon. Responsible States suffering a huge burden created by methamphetamine abuse will not need to change misdemeanors to felonies or be hamstrung by jurisdictional boundaries. Local law enforcement can investigate, arrest and provide a positive treatment program to new users that will be effective. When their methamphetamine use diminishes, the counseling and probation systems can be applied to DWUI offenders, domestic violence offenders and juvenile tobacco and alcohol use.

Senator ENZI. Dr. Clark.

STATEMENT OF H. WESTLEY CLARK, M.D., J.D., DIRECTOR, CENTER FOR SUBSTANCE ABUSE TREATMENT, SAMHSA, ROCKVILLE, MD

Dr. CLARK. Senator, I was mesmerized by Sergeant Hamilton's comments.

I want to thank you for inviting us here. Mr. Charles Curie, the administrator of the Substance Abuse and Mental Health Services Administration, wanted to be here, but he had previously committed to go to Cairo, Egypt for a meeting for providing services to all people of Iraq. He was unable to be here.

As you know, our focus at the Substance Abuse and Mental Health Services Administration is on treatment and prevention or prevention and treatment. Sergeant Hamilton's comments are very powerful on that.

What we have been trying to do is use our limited resources to commit jurisdictions, whether they are rural or urban, to address the methamphetamine problem.

Dr. Rawson pointed out that we don't do research at SAMHSA, but we did one research project, because there was a tremendous absence of information on how to treat methamphetamine. Dr. Rawson's project was one of the projects funded in 1998.

We have come up with a bunch of materials to train people using our ATTCs. We have what we call addiction technology transfer centers, because the substance abuse treatment workforce is, as Mr. Robinson pointed out, in great need and a large amount of turnover. Using our ATTCs, we have come up with materials, electronic materials, face-to-face materials, and I have given your staff a package of this.

We have come up with DVDs and CDs. We have come up with what we call our treatment improvement protocols so that—on the stimulant use disorders, and we have got a number of other things which are, again, in the packet. But the key issue is we are providing funds, we are providing training and we're supporting, along with the DEA and other entities within the Department of Justice, a statewide methamphetamine focus meeting. But what I liked about your comment is that it involved people in specific jurisdictions more than it does the feds. We are facilitators of dialogue.

I was recently at an Arizona meeting. The Governor was there, the attorney general was there, treatment was there, law enforcement was there, private industry was there. That's the kind of intensive commitment, because as long as the community permits methamphetamine to be used, it will be used, and Sergeant Hamilton's point is a point that's well taken.

We need to have treatment and prevention strategies coupled with law enforcement strategy. We need a full continuum. At SAMHSA we're committed to that, with block grants, with our discretionary portfolio.

Wyoming also has an Access to Recovery initiative. We were just talking to Steve Gilmore earlier. That's a very positive initiative involving safe communities, community-based organizations to give people choice and to allow people to focus on making treatment decisions in their best interest, and we are getting a lot of support for our Access to Recovery initiative in jurisdictions. Wyoming is doing very well in that initiative.

The key issue for us is to use our limited resources, to work with States and tribes, cities and counties so that we can make sure that information is available for treatment providers and that jurisdictions can choose to prioritize how they spend their money.

Wyoming is also a recipient of our strategic prevention framework initiative which involves underage drinking, and the Governor's wife can speak to that, but that's also tied to methamphetamine use.

Senator ENZI. Thank you very much.

[The prepared statement of Dr. Clark follows:]

PREPARED STATEMENT OF H. WESTLEY CLARK, M.D., J.D.

Mr. Chairman, good afternoon. I am Westley Clark, Director of the Center for Substance Abuse Treatment within the Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (HHS). Our Administrator, Charles Curie, would have come to participate, but he was committed to go to Cairo, Egypt, for a meeting on providing mental health services to the people of Iraq.

I greatly appreciate the opportunity to testify today in your home State on a disease that is not only affecting the people of Wyoming but millions of people across the United States. According to SAMHSA's National Survey on Drug Use and Health, in 2004, 19.1 million people, age 12 and older, had used an illicit drug in the past month. Whether they use heroin, marijuana, methamphetamine, cocaine, or abuse prescription drugs, the health, social, and economic costs are substantial, including continued substance addiction, lost productivity, premature death, unemployment, homelessness, diminished educational advancement, and possible criminal involvement.

We have compelling data that show the Federal investments in prevention and treatment are a cost-effective and beneficial response to substance abuse. Prevention *does* reduce substance abuse. Treatment *does* help people triumph over addiction and lead to recovery. For example, SAMHSA's National Treatment Improvement Evaluation Study, a congressionally mandated, 5-year evaluation of substance abuse treatment programs, found a 50 percent reduction in drug use among clients 1 year after treatment. Clients included in this evaluation study were from underserved populations and included minorities, pregnant and at-risk women, youth, public housing residents, welfare recipients, and those in the criminal justice system. The study also reported a nearly 80 percent reduction in criminal activity, a 43 percent decrease in homelessness, and a nearly 20 percent increase in employment.

Our findings are corroborated by other studies, among them, the Drug Abuse Treatment Outcomes Study, a National Institute on Drug Abuse (NIDA) study of over 10,000 clients who received treatment in 96 programs in 11 large U.S. cities.

While substance abuse treatment is clearly effective, we must also work to prevent substance abuse in the first place. As you know, the President set aggressive goals to reduce drug use in America. Today, with effective prevention efforts, rates of substance use among the Nation's youth are dropping. This decline in substance use among our Nation's youth suggests that our work, joined with the work of our Federal partners, and the extensive community-based work of schools, parents, teachers, law enforcement, religious leaders, and local anti-drug coalitions, is having an effect.

SAMHSA'S ROLE

I was asked to testify this afternoon on SAMHSA's programs to address the prevention and treatment of substance abuse and about our efforts to hold our grantees and ourselves accountable.

I would like to start by discussing how SAMHSA is weaving accountability into our substance abuse prevention and treatment efforts.

To focus and guide our program development and resources, we have developed a Matrix of program priorities that pinpoint SAMHSA's leadership and management responsibilities. These responsibilities were developed as a result of discussions with members of Congress, SAMHSA's National Advisory Councils, constituency groups, people working in the field, and people working to obtain and sustain recovery. The Matrix priorities are also aligned with the priorities of the Administration and HHS

Secretary Leavitt, whose support for our vision of a life in the community for everyone we appreciate. They guide us as we make policy and budget decisions.

To accomplish our priorities SAMHSA is building our programs around three key principles: *accountability, capacity, and effectiveness*—ACE.

To promote *accountability*, SAMHSA tracks national trends, establishes measurement and reporting systems, develops standards to monitor service systems, and works to achieve excellence in management practices in addiction treatment and substance abuse prevention. We are demanding greater accountability of our grantees in the choice of treatment and prevention interventions they set in place and in the ways in which program outcomes meet the identified needs for services.

By assessing resources, supporting systems of community-based care, improving service financing and organization, and promoting a strong, well-educated workforce that is grounded in today's best practices and known-effective interventions, SAMHSA is enhancing the Nation's *capacity* to serve people with or at risk for substance use disorders.

SAMHSA also helps assure service *effectiveness* by assessing delivery practices, identifying and promoting evidence-based approaches to care, implementing and evaluating innovative services, and providing workforce training.

NATIONAL OUTCOME DOMAINS

Working in collaboration with States and other stakeholders, we have identified and received global agreement on 10 key national outcome domains that emphasize real results for people with or at risk for substance use disorders.

The first and foremost domain is abstinence from drug use and alcohol abuse. Four domains focus on resilience and sustaining recovery. These include getting and keeping a job or enrolling and staying in school; decreased involvement with the criminal justice system; securing a safe, decent, and stable place to live; and social connectedness to and support from others in the community such as family, friends, co-workers, and classmates. Two domains look directly at the treatment process itself in terms of available services and services provided. One of these measures increased access to services for both mental health and substance abuse, and another looks into increased retention in services for substance abuse treatment. The final three domains examine the quality of services provided. These include client perception of care, cost-effectiveness, and use of evidenced-based practices in treatment.

Each domain represents an outcome that you, SAMHSA, and the American people expect from successful substance abuse treatment systems. More important, these are the outcomes that help people obtain and sustain recovery.

By using the same outcome domains and their measures over time to assess progress, States and SAMHSA can foster continuous program and policy improvement. By using the same national outcome domains across all of SAMHSA's State and community-based programs, we will be able to report nationally aggregated data in standard periodic and special reports. We will know with significant precision, as will you, the Administration, and the public, whether the service system is improving and whether we are meeting the President's goals to reduce substance abuse nationwide. Moreover, we will be able to identify—and you will be able to know about—gaps or issues that need to be rectified at the national level. Our grantees, and SAMHSA, in turn, will be accountable for positive results. Perhaps most critically, we will be able to see just how well we are promoting recovery and the vision of a life in the community for everyone.

While grantees under our discretionary grant programs are providing this data now, it has been and continues to be more of a challenge with our block grant program, largely because we are talking about change to systems of care and not just to a specific grant. Despite this, States are committed to provide outcome data by the end of 2007.

We are very pleased with the progress we have made with the States and look forward to not only gathering the data but using it to make decisions and to improve services.

SAMHSA PROGRAMS

Now let me discuss some of the major programs that SAMHSA funds to assist States and communities in addressing substance abuse in their communities.

For fiscal year 2007 the President has requested nearly $1.8 billion for the **Substance Abuse Prevention and Treatment Block Grant**. These funds are distributed to States using a formula dictated in statute. While there are some requirements that States must meet as a condition of receiving the funds, States have great flexibility in their use of the funds. Across the United States, Block Grant

funds account for just over 40 percent of all State funding on substance abuse prevention and treatment. One requirement of the program is that the State must spend at least 20 percent of its allotment on primary prevention. This amounts to $334 million across all States. Wyoming this year received $3.3 million under the Substance Abuse Prevention and Treatment Block Grant program.

Besides the Block Grant, SAMHSA has funds for which public and nonprofit private entities are eligible to compete. SAMHSA publishes notices about the availability of program funds.

Entities submit applications which are reviewed and scored by experts from outside Federal employment, and SAMHSA funds those with the best scores. This year we have $592 million in appropriated funds for discretionary grants and an additional $80 million for Drug Free Community Programs, which are discussed below. Most of these funds will be used to continue grants that were awarded in previous years. To learn what new funds are available, interested people can go to our Web site at *www.samhsa.gov* and click on "Grants." For fiscal year 2005, Wyoming received $5.3 million in substance abuse prevention and treatment discretionary funding. For details on who is receiving those funds, one can go to our Web site and click on State Funding.

I want to take a moment to highlight just a few of the programs that we have.

Providing people with the opportunity to obtain and sustain recovery is at the heart of the President's **Access to Recovery** (ATR) Initiative. This program fosters consumer choice, introduces greater accountability and flexibility, and increases treatment capacity by providing individuals with vouchers to pay for the substance abuse clinical treatment and recovery support services they need. In 2004, 44 States and 22 American Indian tribes submitted applications. Fourteen States and one American Indian Tribe received a 3-year grant under this program. As you know, Wyoming received an award of $2.9 million over 3 years to address methamphetamine abuse in the State.

Despite requesting additional funding for the program in both fiscal years 2005 and 2006, the program was level funded, and all those funds were used to continue the existing grants. For fiscal year 2007, the President has requested $98.2 million for the ATR program to continue to implement the President's commitment to expand consumer choice and access to effective substance abuse treatment and recovery support services by including Faith- and Community-based providers.

Of the $98.2 million, $25 million will be targeted to help individuals recover from methamphetamine abuse. The $25 million will fund approximately 10 grants of almost $2.5 million a year for 3 years. The program will focus on applicants from those States whose epidemiological data and treatment data indicate high methamphetamine prevalence and treatment prevalence.

ATR funding for fiscal year 2007 of $70 million is proposed for a Voucher Incentive Program, which will provide up to 25 grant awards of between $1 million and $5 million to applicant States and Tribal Organizations to expand consumer choice through the use of vouchers. Vouchers provide an unparalleled opportunity to create profound change in substance abuse treatment financing, service delivery, and accountability in America.

The **Strategic Prevention Framework** (SPF) program helps move the President's vision of a healthier United States to State- and community-based action. The SPF State incentive grants provide funding to States to establish and implement a statewide comprehensive prevention strategy. At the end of this year, 40 States and American Indian Tribes will have received a SPF grant of $2.3 million a year for 5 years. Wyoming has a SPF grant which will continue with SAMHSA support through fiscal year 2009.

The success of the framework is and will be determined in large part on the tremendous work that comes from grass-roots community anti-drug coalitions. SAMHSA will continue working with the Office of National Drug Control Policy throughout 2006 to support 720 grantees funded through the **Drug Free Communities** grant program. Under this program, local coalitions receive $100,000 a year for 5 years to continue community-based efforts to prevent drug abuse. Grants awarded in 2006 will have a particular emphasis on underage drinking. Wyoming currently has four such grants, including one here in Casper—Natrona County School District.

SAMHSA's **Targeted Capacity Expansion** (TCE) grants, for which the Administration has requested $21 million for fiscal year 2007, are to expand and/or enhance the community's ability to provide a comprehensive, integrated, and community-based response to a targeted, well-documented substance abuse treatment capacity problem and/or improve the quality and intensity of services. For example, a community might seek a TCE grant to add state-of-the-art treatment approaches or new services to address emerging trends or unmet needs.

As we financially support State and local providers in their efforts to prevent and treat substance abuse, we are working to ensure that consumers and providers of substance abuse services are aware of the latest interventions and treatments. One important tool being used to accelerate the "Science to Service" agenda is SAMHSA's National Registry of Evidenced-based Program and Practices. Last week we released a *Federal Register* Notice about the registry and how it has been and will continue to provide guidance to States and local community organizations in choosing prevention and treatment modalities.

Education and dissemination of knowledge are key to combating substance abuse. SAMHSA's Addiction Technology Transfer Centers are providing training, workshops, and conferences to the field regarding drug use. It is an ATTC that developed the discs outlining cognitive behavioral approaches to the treatment of methamphetamine abuse and in particular the MATRIX model.

SAMHSA develops Treatment Improvement Protocols (TIPs) on various subjects related to substance abuse. For example, in 1999, SAMHSA first published TIP No. 33, entitled "Treatment for Stimulant Use Disorders," which has been reprinted twice. Every 2 years, we take another look at each TIP to update it as needed.

I would be remiss if I did not mention that on April 5–7, SAMHSA is sponsoring a conference on methamphetamine in Los Angeles for all States west of the Mississippi River. We are paying for each State to bring up to 15 individuals, including State officials and providers. The States on the east side of the Mississippi will have their conference in Orlando the week of May 23rd.

CONCLUSION

Again, Mr. Chairman, I thank you for the opportunity to discuss SAMHSA and its programs. We look forward to working with you on expanding the services we provide and in improving the accountability systems currently in place to ensure that Federal funds are being used effectively and efficiently.

Senator ENZI. I'm sorry you didn't get to make the trip to Egypt, but I very much appreciate your being here to share with everybody some of the Federal initiatives that are being done that we want everybody in Wyoming to be aware of. And, of course, the mechanism by which we're going to use this information will be on the reauthorization of SAMHSA.

What's said here today may well affect you. I'm glad you're here taking notes as well. Thank you.

With that little bit of an introduction, again, to your first lady, I will go to First Lady Nancy Freudenthal.

STATEMENT OF NANCY FREUDENTHAL, WYOMING'S FIRST LADY, CHEYENNE, WY

Ms. FREUDENTHAL. Thank you, Mr. Chairman.

I would like to, I guess, move the discussion in a different direction, a direction that really focuses on prevention.

I would take issue, I think, with some of Sergeant Hamilton's comments in terms of treatment being the No. 1 priority.

My testimony here today is emphasizing the importance of community-based environmental strategies that look at and reinforce various domains where you can make change in terms of affecting the norms on both alcohol use as well as illegal drug use.

In following up on Dr. Clark's testimony on SAMHSA reauthorization, I would like to encourage the committee to really focus the emphasis of substance abuse prevention from mostly individual behaviorally based programs to a comprehensive communitywide strategy.

For the Wyoming First Lady's Initiative, we have a large poster that talks about how blaming children for drinking is much like blaming fish for dying in a polluted stream.

We're talking about an environment in which our children and our citizens live, and if we can look at prevention from a comprehensive communitywide strategy much like the model of the First Lady's Initiative, which is really a bottom up initiative as opposed to a top down initiative, an initiative that partners with a number of other entities and builds with—on the back of the passion of advocates in the community like Mr. Pagel and others who are part of the First Lady's Initiative.

It's never enough to put the responsibility solely on the back of the individual, whether it's not to drink or to refrain from using drugs or to seek treatment. That's not enough.

I think we do need to look at prevention from this communitywide strategy and from a multiple strategy where targeting parents, targeting use, targeting schools, targeting communities and having messages in those various domains reinforce each other. I think science tells us that the impact of having positive change with that approach is improved.

I would like to—because I'm talking about underage drinking or the childhood drinking initiative—I would like to link a little bit more closely to meth use.

The First Lady's Initiative was recognized in the Governor's 2006 State of the State address to the legislature. I was very honored and pleased with that. He recognized it not only as a model or a template for attacking problems such as meth use, but he also connected the dots between childhood drinking and illicit use of drugs.

Now, we know that early onset of drinking by children is a real predictor of much of the serious problems to come. We know that the statistics about the children that drink are likely to perpetrate violence as well as become the victim of violence, become the victim of assaults, suicides, early and unplanned sexual activity and accidents.

We have also heard the statistic that 40 percent of children who start drinking before the age of 15 will develop alcohol or drug abuse dependencies at some point in their life, 40 percent. That's almost half of kids drinking under an age of 14 are—have at some point in their time—looking at a drug or alcohol dependency.

Wyoming ranked first for children drinking under the age of 13. This particular statistic I think should be alarming for us.

Now, as though that information were not bad enough, I recently received research linking early childhood drinking to later use of stimulant drugs. This research came through the director of the Division of Epidemiology and Prevention Research at NI triple A.

The research came from a draft manuscript from Dr. John Herman sent to the Boston University Youth Alcohol Prevention Center. Dr. Herman sets research that shows the younger the age respondents first drank alcohol, the larger the percentage who then later illegally used stimulants. Specifically, literally one quarter of the respondents who drank under the age of 14 reported illegally using stimulants, which would include meth.

This percentage is even more dramatic when you compare it to the percentage of respondents who waited to drink until they were the legal drinking age, 21 or later. Only 2 percent, only 2 percent of those respondents say that they later, then, participated in using illegal stimulants.

What does that tell us? It tells us that these early-onset drinkers are 11 times more likely to then enter into these other activities of use of stimulant drugs.

For me, the lesson is clear. We ignore childhood drinking at our peril. To quote the Governor in his message, "we can more effectively address meth problems by redoubling our attention to teenage and preteen alcohol use."

I would just like to encourage you, Senator, and your committee when you're looking at the reauthorization of SAMHSA to put an emphasis on prevention and to consider including the provisions from the stop underage drinking act, the sober truth in preventing drinking act.

There is no question that prevention has been underutilized both as to funding and emphasis relating to its importance and effectiveness in reducing drug and alcohol use and their related human and social impacts.

Thank you.

Senator ENZI. Thank you.

You will be pleased to know that yesterday in the Governor's speech, he again mentioned the First Lady's Initiative and the difficulty with underage drinking and how that also relates, then, to experimenting with other drugs, and some of them are not experimentable, like methamphetamine.

So, thank you.

[The prepared statement of Ms. Freudenthal follows:]

PREPARED STATEMENT OF FIRST LADY NANCY FREUDENTHAL

Good afternoon Senator Enzi and members of this roundtable discussion. My name is Nancy Freudenthal and I am here today as Wyoming's First Lady and also as a representative of the Wyoming First Lady's Initiative to reduce childhood drinking. I am pleased to participate and provide information for the Committee on Health, Education, Labor, and Pensions, as it looks at State and local initiatives to combat meth use and as it generally prepares for the reauthorization of the Substance Abuse and Mental Health Service Administration (SAMHSA).

My comments will focus primarily on the First Lady's Initiative. I was pleased and honored to have the work of the Initiative recognized in the Governor's 2006 State of the State message to the legislature. I brought an excerpt of his message for the record. The Governor's message made some important points relevant to this roundtable discussion.

The first point made in his message is that the Wyoming First Lady's Initiative can set a template for attacking the related and equally frightening problem of methamphetamine use.

Under WFLI, we have brought together a statewide network of passionate advocates concerned with the public health problem of childhood drinking. These advocates are dealing with this issue from the community level—a "bottoms-up" approach, rather than using the traditional "top-down" model. The Initiative also emphasizes inclusion and partnership.

Specifically, we have partnered with State agencies, law enforcement, liquor and beer distributors and retailers, the military, judges, business owners, the faith community, the nonprofit sector, teachers, school administrators, local government officials, parents and students—to change attitudes starting in each Wyoming community. Our team members have been incredible. With our team members, we have empowered local community efforts, provided resources and training, bought advertising, published statistics, collected news articles, distributed parent handbooks, posted "best practice" ordinances, advocated policy changes, held town hall meetings, mailed letters to nearly 16,000 Wyoming households, and engaged conversations all over our State—with one aim—trying to be a supportive voice for change within Wyoming.

The experiences have been marvelous. FE Warren is leading the military with its 0-0-1-3 program, which started from WFLI training. People are engaged and talking about everything from the location of the beer tent at the county fair, to whether

schools have good alcohol policies, to why parents, siblings and other adults supply alcohol to kids. We're trying to take prevention directly to all fronts: parents, schools and communities. Also, one of the most exciting developments is that our Wyoming students are taking a leadership role and showing real results in reducing risky behavior.

In short, we are hoping that each targeted prevention domain (youth, parent, schools and community) is reinforced by the other in order to bring about the best impact.

The lesson learned from WFLI is that this sort of community-based environmental strategy, which targets the most effective domains for change, can strengthen norms against childhood drinking.

Along this same line, the SAMHSA reauthorization needs to help refocus the emphasis of substance abuse prevention from mostly individual, behaviorally based programs to similar comprehensive community-wide strategies. It will never be enough to put the responsibility *solely* on the back of the individual—whether it is to refrain from drinking until 21, or to not use drugs, or to seek treatment for alcohol or drug use and abuse. The SAMHSA reauthorization must emphasize *multiple* strategies that create a comprehensive blend of individually and environmentally-focused efforts.

The second point made in the Governor's 2006 message to the Legislature is that early alcohol use by children is a predictor of more serious problems, including meth use. We know that children who drink put themselves at risk of perpetrating violence or becoming a victim of violence, suicide, unplanned and early sexual activity, and accidental injury and death. We've also heard the statistic that 40 percent of children who start drinking before the age of 15 will develop alcohol or drug abuse or dependence at some point in their lives.

As though this information is not worrisome enough, I recently received research linking early childhood drinking to later use of illicit stimulant drugs from the Director of the Division of Epidemiology and Prevention Research in the National Institute of Alcohol Abuse and Alcoholism. This research comes from a draft manuscript by Dr. John Hermos at the Boston University Youth Alcohol Prevention Center. Dr. Hermos' research clearly shows the younger kids first drink alcohol, the larger the percentage who then illegally used stimulants sometime in their lives.

Specifically, nearly ¼ (23 percent) of all respondents who said they drank before the age of 14 also reported illegally using stimulants, which would include meth. This percentage is even more dramatic when compared to those who waited to drink until they were 21. Only 2 percent of those respondents went on to then illegally use stimulants. This research tells us that early users of alcohol are *11 times* more likely to later use stimulants compared to respondents who waited to drink until they reached the legal drinking age.

The lesson here seems clear. We ignore childhood drinking at our serious peril. To quote the Governor, "we can more effectively address meth problems by redoubling our attention to teenage and preteen alcohol use."

Thank you Senator Enzi for your commitment to this important issue. I encourage your committee to reauthorize SAMHSA with a strong emphasis on prevention and with provision that reflect the Sober Truth on Preventing (STOP) Underage Drinking Act. There is no question that prevention has been under utilized, both as to funding and emphasis relative to its importance and effectiveness in reducing drug and alcohol use and their related human and societal costs.

The WFLI prevention work has been both rewarding and productive. I am convinced that its emphasis on partnership, cooperation and comprehensive, community-wide environmental strategies will change norms and save lives. I am also convinced that increased resources for community coalitions and States to enhance underage drinking prevention efforts will be a positive and important step forward in the fight against meth use, for all America—rural and urban.

Thank you.

Senator ENZI. Ms. Searcy.

STATEMENT OF MARGEAN SEARCY, SALT LAKE CITY POLICE DEPARTMENT, SALT LAKE CITY, UT

Ms. SEARCY. Thank you for convening this roundtable, Senator.

Utah started to see its methamphetamine issue around the early 1990s. By 1998, we were at a peak as far as methamphetamine labs, clandestine labs, and we were doing our best to equip first responders and kind of gear up for that.

We also did some pre-emptive stuff in the early 1990s where we put some legislation in place to strip precursor chemicals, because we saw this coming across the western United States and we knew that soon it would hit Utah.

We also started working interdisciplinary teams. We started putting together a task force to work on meth issues, and by 1998 the Salt Lake City Police Department had put together the Cops Meth Initiative with over 30 agencies to work on this issue.

We started a public awareness campaign, started identifying victims. When we talk about victims, oftentimes nationally we talk about children, but I think it's very important that we don't miss the elderly people as well.

With our response, we have witnessed a 67 percent decrease in the number of meth labs. However, arrests for methamphetamine distribution and use in just Salt Lake City alone has gone up over 208 percent from 1999 to the year 2005. That's a big increase for us.

To put that into perspective, overall arrests for all drugs have stayed—you know, have not had an increase, because we're topping out at our ability for resources. We're using all the resources that we currently have for that.

We know that there was a direct correlation between crime and social issues associated with substance abuse. Some of the things that we're seeing with methamphetamine are being reported nationally, those being identification thefts, financial crimes. We're seeing an increase in counter-surveillance, which is a problem for law enforcement people first coming on scene. We're seeing high tech weapons.

Environmental conditions really concern us, some of the studies that Denver has done with a smoke study as far as methamphetamine and some of their first responder studies. We're seeing highly sexualized environments and overall disregard for taking care of the home and cleanliness.

In Utah, meth outplaced marijuana back in 2001 and has continued to be on the rise. Between 2003 to 2005, we have seen an upward spike with people entering treatment saying that methamphetamine is their primary problem. Then we look at our data more closely and we see that women are using at a much higher rate than men, and it's significant. Also, when you break this down further, we see that the women that are using are between the age 25 and 45, which we know that women during the age 25 to 45 are in their childbearing years.

The estimated—or the average of people entering treatment with dependent children, the dependent children on average are two.

One thing that Utah has really been focused on is increasing treatment programs that are family oriented. One barrier for parents with dependent children entering treatment is what to do with their dependent children. Focusing on that has been a thing that we've really looked at lately.

Sixty-eight percent of the kids coming into Utah custody in 2005 had a contributing factor of substance abuse. Back in 1998, there was 31 percent. We have seen an extreme increase in that arena as well.

Our capacity for treatment versus our need—60 percent of our referrals at this point in time coming into our treatment system in Utah are from our criminal justice system, and we have people waiting on lists to get into treatment for upwards of 3 months.

That is a problem for us. One of the reasons we're here is for reauthorization of the Substance Abuse and Mental Health Services Administration.

One of the things that I wanted to bring to you today that we think is important in Utah is increasing foundation funding for treatment services and mental health services. Meth—the average that I have heard thrown out is that meth takes about 10 to 15 percent longer to treat.

I know that this is a bad time to ask for more money, but we need more money for treatment. If we are putting together collaboration between agencies but we don't have a place to treat people once they get there—law enforcement does the work. Treatment services does the work, child protection. If we don't have places to treat people and treat families, then we're going to cause ourselves a lot more costs in the long-term.

Thank you.

Senator ENZI. Thank you.

Mr. Sniffin.

STATEMENT OF BILL SNIFFIN, CEO, WYOMING INCORPORATED, LANDER, WY

Mr. SNIFFIN. I'll scoot up over here.

Thank you, Senator, for calling this hearing and thanks for the invite.

I certainly have been enjoying and I am impressed by what I am hearing around the table. I think I can also say as an observer—I have been a journalist in Wyoming for 36 years, and that's one of the reasons I'm here—but I think I can honestly say that Wyoming is in pretty darned good hands right now with the first lady doing what she's doing and with Anna. We have been watching what she has been doing, obviously, and we have worked with her and Steve Gilmore and Rodger McDaniel, and the list goes on, Tom Pagel and the different community things.

But my role in this is, we own an ad agency called Wyoming, Incorporated. We actually got into this business to help Wyoming with social marketing and to raise awareness. Awareness equals prevention or prevention equals awareness. They go hand in hand.

Also a personal note, Senator. When you were first campaigning in Lander, you and I went down to my son's baseball team. Mike is a heck of a baseball coach. But anyway, one of the reasons I got into this is that my son ended up being quite a drug addict and was in and out of treatment for a long time.

When I came to this job, it wasn't just for a job. It was personal. This was something that we—my wife is sitting out there.

We have been through a lot, haven't we?

But anyway, it didn't take long when we got into this to realize that there is a heck of a story to be told. I think the reason the Senator asked me to be on this panel is, because of my background in the media business, we were able to marshal free media forces in the State of Wyoming. I think it's between $230,000 to $300,000

in in-kind media we have been able to get. It's not just been our good work. Again, it's been Tom Pagel and Anna and Steve, and Rodger has done a tremendous amount over there.

But what we did is we—I remember a meeting in 2003 of police chiefs in Wyoming, and a comment came out that I have never forgotten. It was: "We cannot arrest our way out of this problem. We need the communities to deal with this."

We came up with a campaign called Wyoming Faces Meth. There is a play on words there, and it's "Wyoming faces." We didn't hire actors to do the commercials. We went down to the treatment centers and actually interviewed real people in treatment for meth. Their stories were astonishing. One of the things that came out of it was these were not sort of the low-income kids. These were kids that covered the whole spectrum of Wyoming society. The other thing that came out was just how difficult meth addiction was to deal with. It's a terrible issue.

I do have other things I am going to say, but as part of it, we distributed 300,000 of these, and we decided that we needed to not just go directly to the addict, but we felt we needed to go to mom, dad, husband, wife, brother, employer and get everybody involved. Certainly to echo what the first lady is saying, that's how it works. You really have to get everybody involved, because a lot of times the addict is gone. He or she may want to get off it, but he or she doesn't.

But then what we did with—got a timer over there telling me I'm talking too long.

The other thing we did is TV commercials with these folks, and we were able to negotiate $100,000 worth of free cable advertising on MTV and all these channels through Bresnan Communications that were aired after midnight, because the same law enforcement people told us that whenever they had a raid, MTV was on and it was 2 a.m.

We did direct a message to the addicts, too. I'll talk a little more about that later.

Thank you, Senator.

Senator ENZI. Thank you.

[The prepared statement of Mr. Sniffin follows:]

PREPARED STATEMENT OF BILL SNIFFIN, CEO, WYOMING INC, LANDER, WY

The curse of Methamphetamine addiction is something that I am very familiar with, from at least three different directions over the past 7 years.

- Our son has been in and out of trouble during that time for a variety of substance abuse violations, including abuse of Meth.
- As a journalist, I wrote about the problems of Meth and other substance abuse issues during a 36-year career in Wyoming.
- As owner of a PR and Marketing firm called Wyoming, Inc, our company has had the Social Marketing contract with the Department of Health, Substance Abuse Division for the past 3 years.

With the above introduction, I can say that programs that raise awareness of the problem are critical to the success of any effort.

When we started with our first contract in 2003, the people of Wyoming were still pretty much in the dark about the perils of Meth, although a large population of State residents were already experimenting with the drug.

Our first campaign involved real Wyoming people who were in treatment in Rock Springs.

With the theme WYOMING FACES METH, our task was to tell every man, woman and child in the State about the perils of Meth. Our plan was that by informing parents, siblings, employers, policymakers and all citizens, we would create

an environment where Meth use would be universally known as a bad thing and something to be avoided.

Our main tool in this campaign was distribution of nearly 300,000 newspaper inserts plus the airing of thousands of TV commercials on both broadcast TV and cable TV.

We also launched a gigantic Public Relations and Earned Media campaign utilizing every media outlet in the State.

As for the campaign directed to the addict on a personal level, we were able to work with Bresnan Cable as they donated more than $100,000 in advertising space on their late night channels like MTV, which law enforcement people had told us were usually being watched by addicts.

One of the most important aspects of our campaign was a branding. After working with focus groups and a great many Wyoming people already in treatment, we came up with the branding of "I AM FREE OF METH, I AM TRUE TO MYSELF?"—or free and true. We created a nationally recognized web site called freeandtrue.com.

In 2005, we launched a new statewide campaign that focused more on the message that treatment works. It utilized newspaper and radio and billboards.

Meth affects everyone. Without a big-time awareness effort, it is impossible to deal with the problem. Our efforts worked very well and were rewarded with lots of national recognition including 14 Telly awards for our TV commercials and resulted in me giving a presentation at the 2004 CADCA conference in Washington, DC.

Meth is too big a problem. As a County Sheriff told me back in 2003, "We cannot do it alone. We cannot arrest our way out of this Meth epidemic." By getting everyone involved through awareness, we have a much better chance to dealing with this serious problem.

Senator ENZI. Dr. Fagnant.

STATEMENT OF ROBERT J. FAGNANT, M.D., FACOG, FACS, ROCK SPRINGS, WY

Dr. FAGNANT. Thank you, Senator Enzi.

As an initial aside or my aside first is, I had recently served on the American College of Obstetricians and Gynecologists Adolescent Health Committee and we consider SAMHSA a very good resource. So, appreciate the information they provide.

In 2005, several methamphetamine addicts delivered at Memorial Hospital of Sweetwater County in Rock Springs. We delivered 565 babies last year. When we delivered those addicts, we attempted to get help, assistance for them and found it very, very difficult, and very little was able to be done despite reporting to law enforcement and DFS.

Because of that difficulty and the frustration of those agencies as well, we were able to come together, and through a series of meetings a policy was able to be generated through Memorial Hospital of Sweetwater County.

Since that time, in the year 2005, nine babies were identified, sent to DFS. Of that, all nine mothers remain in treatment and eight of those babies still remain in foster care.

The sad thing about those numbers is those numbers are mostly from the very end of the year, because from the middle toward the end of the year is when we were trying to develop the policy to work.

I would be willing to share that policy and how we came up with it and the frustrations we experienced as far as all the roadblocks seem to be in the way of trying to get health care to the meth addicted mothers. Part of that resulted in a bill that never made it through the legislature for methamphetamine to protect the unborn child.

Thank you.

Senator ENZI. Thank you.

[The prepared statement of Dr. Fagnant follows:]

ROBERT J. FAGNANT, MD, FACOG FACS,
ROCK SPRINGS, WY,
March 21, 2006.

Hon. MICHAEL B. ENZI,
Chairman,
U.S. Senate,
Committee on Health, Education, Labor, and Pensions,
Washington, D.C. 20510.

DEAR SENATOR ENZI AND COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS: Thank you for inviting me to present my comments at the roundtable discussion on methamphetamine use in rural areas, which is taking place on March 23, 2006 in Casper, Wyoming.

Having been born, raised, and educated through college in Wyoming, I had seen little abuse of drugs other than alcohol. During my medical training, I had exposure to many people with numerous addictions and dependencies to a multitude of drugs. Methamphetamine, or one of its close relatives, was around and was abused but was considered by both the medical community and the drug abusers we came in contact with as minimal if even a problem at all. In the 18 years of practicing obstetrics and gynecology in Rock Springs, Wyoming I have witnessed a growing problem among my patients and their families regarding methamphetamine. I have witnessed patients and even a hospital employee change their entire personalities as they became more dependent on methamphetamine.

In Wyoming several attempts have been made over the last several years to protect the children of the women who abuse the drug, as well as to treat the women during and after pregnancy to get them off meth. Despite these attempts legally, legislatively, medically, and socially little has seemed to make an impact on the problem.

In January 2005 several methamphetamine addicts delivered babies at Memorial Hospital of Sweetwater County. Several agencies decided to come together and try to deal with the problem. Groups of people have done similar things throughout the State of Wyoming. After multiple meetings a policy was developed to manage methamphetamine positive pregnant women. The statistics aren't formal but around 11 women tested positive for methamphetamine while in labor during 2005. Of the 11, 7 babies tested positive. The women were referred to the Department of Social Services, which placed the babies in foster care. Most of those babies remain in foster care. The numbers are not complete as most of the women who tested positive were identified at the beginning of the year when an effort was made by the health care providers to identify the problem. The testing decreased for most of the rest of the first half of the year, as there was much controversy over who could be tested and what should be done if the testing was positive. Toward the end of the year the policy came in effect and more reporting resulted.

The purpose of the policy is to offer mothers who abuse methamphetamine and other substances a drug treatment program, and to protect the newborn from a substance-abusing environment. Risk factors as published by prior studies were identified. In women who had any of the risk factors, urine for toxicology was obtained upon order of the physician. If the test was positive, a urine and stool test for toxicology was obtained from the newborn. A 48-hour legal hold would be anticipated while the hospital social worker or child protective services were consulted. The results are reported to the Rock Springs Police Department where a search warrant is obtained and a stool specimen from the newborn is taken for forensic testing.

In my practice, I ask the high-risk women if we can do serial urine screens for drugs of abuse. None of my patients have refused. There does not seem to be avoidance of prenatal visits for these high-risk patients more than in similar women who are not asked. The women still deliver at the hospital.

Many questions remain. A bill failed at the recent Wyoming legislative session that would have clarified the abuse of the unborn child. District Attorney's offices across the State take different stances on whom to prosecute. There is concern if there will be enough foster homes for the children. It is unknown how long a mother will need to be in treatment before the baby can be taken care of by the addict.

Although many "birth defects" and pregnancy complications have been attributed to using methamphetamine there is very little good data that can directly link these abnormalities. Those who work with meth addicted mothers however can easily see the social and physical impact that occurs to the child even immediately after taken

home by the mother. No matter how well meaning the mom is she is just unable to care for her newborn.

Respectfully,

ROBERT J. FAGNANT, MD, FACOG FACS.

Senator ENZI. Ms. Martin.

STATEMENT OF SHERRY MARTIN, DIRECTOR-CEO, FAMILY WHOLENESS, CASPER, WY

Ms. MARTIN. Senator, I am honored to be here, and I am really grateful to be able to be here on a different perspective of being able to speak from my heart.

I appreciate, Michelle, the ability to do that in DC. when I was there a month ago to begin this process. I'm really grateful to hear on this panel—I'm very new to it—Mrs. Freudenthal's comments on the community, and Mr. Sniffin, just your ability to go specifically to the addicts themselves.

I come from a very personal level in experiencing this all the way from my home, all the way on the streets, here in many different avenues. I believe what my role is today is to speak from the heart of those that we're working with, with testimonies all the way from DC., to the State level, to the local level.

What I would have to say is that I feel very fortunate to be able to work with people hands on.

Family Wholeness is an organization that has just recently developed out of Access to Recovery. Access to Recovery and what we provide is recovery support services. We realize from a personal level in our own homes to a community level. I think it's very interesting that I was on the first committee with the meth awareness committee here in Casper, and one of the first things that came out of that meeting was that it's a community problem, and so the awareness that it is community that needs to hold hands together and work with this, and yet there is an aspect of it that we understand on a personal level. Treatment is very important, and yet this other aspect of recovery support services—we're very thankful for SAMHSA, SAMHSA through the faith initiative to be able to provide recovery support services.

I believe what we do at that level is at a root level, being able to go—and you're talking about some of the kids to the families. I get to go in homes on a day-to-day basis and work with families and to be able to listen to them and what is really going on.

I believe that recovery support services locks hands with the treatment. Treatment is somewhat like a hospital setting. Yet recovery support services is almost like the emergency room before, during, and after, in that, when there is treatment provided for these people, that's for a certain length of time, and yet recovery support services comes before, comes in the middle and comes after to work with the kids, to work with the family.

I feel extremely fortunate to be able to do that, because I get to hear at a root, root level what's going on in the home, what these kids, what these mothers, what these fathers are saying. I come from a perspective of being a mom, being a friend, being a neighbor, a very personal level.

I want to share with you something that recently happened to me in DC. with an opportunity to walk back from visiting with Michelle very late in the evening, felt really led to walk up a street that didn't look too safe to me on my own as a woman.

In walking up the street, I ran into a homeless man who was a serious meth user. I sat down and talked with him, took him into a McDonald's and just began to talk to him.

I come from a faith-based perspective, felt like that's what the Lord was leading me to do.

When I sat down with him and talked with him, what I first heard was develop a relationship with him. I will tell you this is the No. 1 thing I would stress in this, that from the kids to the parents, what they're saying is relationship, all the way to, what is the best form of detoxing; that I hear, yes, we all know that we have to abstain from it, yes, we know we need treatment, we need help, but the other aspect of detox is relationships. That's what I'm hearing across the board.

As I sat with this homeless man in DC. who was a meth user, I watched as we developed a relationship, his willingness to share his troubles, his problems, all the way to visiting with a young girl the other day who said—and it was very difficult for me to sit with her and say, "What's on your mind? What's going on? And what's helpful for you?"

The No. 1 thing I'm hearing from kids that are dealing with this—and we know there are problems in their home—is, no one cares, no one cares. I said, "How do we battle that? How do we combat that no one cares?"

She pointed to me. She went like this, and she said, "This, relationship, relationship. Hear what I'm saying. It's relationship."

As I began to talk with her a little bit more, it's how can we help? It's this one on one, sitting down in a relationship. I believe that's what recovery support services provides; that it becomes that emergency room for those people. It's not so much focusing on the problem as it is sitting down with people and encouraging them in the things that they are gifted in.

When I talked to the gentleman in DC., his response was—and I got to tell you. He began to talk and make sense as we developed a relationship even though he, I believe at the current time, was using meth. He said to me, "There is not any one of us homeless on the streets that are not hard workers, that realize what we have done is wrong, that realize we have to have consequences. We have lost our licenses. We can't do that."

I said, "What are some of the things that we can do to help?" because I'm experiencing this in Access to Recovery. We provide transportation for those people who have lost their licenses, who realize they need help.

But here is a man saying, "Let me tell you why we're not going into shelters. We know they provide food. We know they provide clothing. We know they provide even programs that will help us get past the issues that we're dealing with. But when we go in, then they say, 'If you do this this way, you can have the food. If you do this this way, you can have the clothing. If you do this this way, you can have the shelter. Otherwise, you're out the door.'"

What they are seeking is relationships, is help along the way, understanding that they do need treatment. How I see recovery support services, and what I do is linking hands not only with treatment but with community service providers, and we're doing that with churches, with families, with businesses all the way across the board.

Thank you.

Senator ENZI. Thank you.

Dr. Christensen.

STATEMENT OF DR. GRANT CHRISTENSEN, DDS, ROCK SPRINGS, WY

Dr. CHRISTENSEN. By the way, besides being a practicing pediatric dentist in Rock Springs, I'm also the staff dentist for the Wyoming Department of Health. About 2 years ago, I got a call from Dr. Debra Fleming, who was then director of the health department, asking me to supply her with information about the effects of methamphetamine on teeth. I had had some experience with that as a pediatric dentist, not seeing a lot of methamphetamine dental abuse, but did some research at that point and became involved with trying to become very familiar with what's called meth mouth.

When I got the invitation to participate in this roundtable, I looked at the two questions and didn't feel like I had a whole lot to contribute to either one of those subjects as a dentist who understands and treats meth mouth, but I thought I must have been asked here for some reason, so I am going to tell you about meth mouth.

Senator ENZI. Good.

Dr. CHRISTENSEN. I'm also going to tell Dr. Rawson, don't worry too much about not being here in the summer. It looks about like this. I can't imagine why anybody would rather go to Cairo than Casper, but——

I'm seeing, even in a pediatric practice, I'm seeing two to three cases of meth mouth a month, and I talked to some of my other colleagues and they are having about the same experience, which tells me that there are a lot of young people who have been doing meth long enough that it's caused damage to their teeth.

I will tell you that meth mouth is the Nagasaki and Hiroshima of dental disease. It is disastrous, and it is complete when it's in full bloom and it is extremely expensive to rehabilitate.

I had a 19-year-old in my office, almost 20-year-old, who was in treatment who—his teeth were just little black nubs. That's all that was left. The substance abuse center in Rock Springs, the Rose Recovery Center, had sent him down to have a tooth extracted because he was in so much pain, and at that time we had a discussion about what his future dental needs were going to be.

He asked me, you know, "I'm going to complete recovery and I am going to get my life all straightened out. What am I going to do about my teeth?"—a good-looking kid with little black stubs where teeth used to be.

I said, "Well, you know, we have limited options. If any of your teeth are restorable, they're going to have to have permanent crowns."

"How much that cost?"

"Oh, $600, $700 a piece."

"Well, what if I just have all my teeth extracted and have dentures?"—a 19-year-old.

I said, "Well, that's option No. 2, and it's certainly the least expensive, but it's going to cost you $4,000 to $5,000 to have all of your teeth extracted and have dentures, which you'll have the rest of your life."

Well, here is a young man, without a job, without insurance, soon to be off of Medicaid and looking at the cheap option of $5,000 for rehabilitation of his mouth to over $30,000 if he has caps and root canals and all the other things, if his teeth were restorable. In his case, they probably weren't.

Well, what that means, then, is that when you're talking about recovery support services and workforce issues and that sort of thing, we may have a lot of young people who are recovered or recovering addicts without any teeth or with teeth that look like the picture that I included in the little handout that I gave you.

That's a mild case right there. I didn't want to make everybody sick so soon after dinner, because I have got some that look a lot worse than that. This is a problem that, you know, when you talk about all of the things that other people around the table have talked about, may pale in comparison, but when it comes down to your life and your future and you're a young person who is trying to get his life back together, this can be a staggering hurdle to overcome.

I thank you for inviting a dentist here today. I feel a little overwhelmed by the expertise that's sitting around the table, but hope that maybe as we look at treatment modalities and treatment problems and outcomes, that you don't forget some of the devastation that's done by this to mouths.

Dental researchers call this the perfect storm of dental pathophysiology. All of the worst elements of dental disease come together in methamphetamine use.

Xerostomia of the dry mouth is the perfect environment for the development of dental caries, dental decay. Add that to a craving for sugar.

Mountain Dew I'm told is the drink of choice, and Mountain Dew has 19 teaspoons of sugar in a 16-ounce bottle, and these people bathe their mouths continually with that stuff because their mouth is dry and they have a craving for sugar.

Add to that the direct effect of one of the most insidious and acidic chemicals that a person could bathe their teeth with. Folks who smoke or snort methamphetamines coat their teeth with this acid that contributes to those other things, and then these people never go to the dentist because they don't have any money. They are spending it on the drugs. They're afraid that their dentist is going to turn them in. They wait until they're in dire consequence—dire need before they show up at a dentist's office.

Thank you so much for letting me come and make that contribution. I wish I had the answer. I'd like to take a poster of some of those mouths and hang them up in every junior high school in the State so the kids can see them. That might make it a little bit more personal for them.

Senator ENZI. I think that Bill Sniffin would probably be the one to help you do that, too. We'll want to hear some more about that a little bit later.

When you say 18 teaspoons of sugar in there, I prefer that you say 18 teaspoons of corn syrup. It helps out our sugar producers. No. I appreciate that.

Majority Leader Frist has spoken on the Senate floor about the meth mouth problem and helped to make an emphasis on that. That's why we definitely wanted to have you as part of the panel to share some of those pictures with us.

Dr. CHRISTENSEN. Thank you.

Senator ENZI. I think that is one of the good deterrents out there.

I know some of you may want to comment on some of the things that other people have said, but in order to move on with the hearing, if you'd put any additional comments that you might have in writing on that, we'll move on to the second question.

That one would be, how have you coordinated your efforts to address meth use and abuse with other public, private entities to improve the outcome? I want to know a little bit more about the coordination that's being done.

Who would like to start on that?

Mr. Pagel.

Mr. PAGEL. Senator, thank you.

I think one of the successes that we have seen in Casper is exactly that. It's a community effort and a collaboration. We have not only municipal and county government with assistance from the State, but our business community, our chamber of commerce, our schools, our hospitals have all joined into this effort, and that's what it's going to take.

I can tell you that you cannot develop at the Federal level a cookie cutter program that you can put out across the country that's going to solve everybody's problems. It is not going to work. But one of the things that you can do is communities can be required to come up with this collaboration, to have these community groups, to come up with a list of their resources and their specific problems so that when they are asking for grant money, they can ask for a specific problem and a specific solution that they are after.

That is important, that it is not a shotgun approach but it is an assessment, evaluation of each individual community, each individual State and what they need to be successful, and that specific request, then, is what is going to allow them to be important.

Everybody's resources are different. Worland is going to approach this differently than Casper does or Cheyenne or Big Horn or whomever you talk to.

That is important, that each community do an assessment and evaluation and have specific requests.

Another point that I would like to make is, we have heard several people around the table tell how long they have been dealing with methamphetamine. Our response is too slow.

I'm not a researcher. Dr. Rawson, I'm sure, does an excellent job on that, and there is a place for that to be done, but we are in a situation that demands action with methamphetamine. Every day

that we wait and every day that we discuss, there is more of it coming into the country, and it's coming in primarily from Mexico.

We can worry about meth labs, and they're a terrible problem, but we're absolutely being hammered by Mexican meth. That's where the vast majority of it is, 70 to 95 percent, depending on who you talk to. I tend to lean toward the highest figure. The majority of our meth is coming in from Mexico, and that has to be addressed at a Federal level.

A final point that I would like to make is, one effort that communities can make is in drug testing. You can stand up as a community and you can say, if you want to work in Casper, Wyoming, you are going to be drug free.

We have over 160 businesses that have stepped up to the plate and have begun drug testing in Casper, and we are sending that message. We have accounting offices. We have professional offices. The energy industry has taken a lead on this, has done it for years, is doing an excellent job.

We have individuals that run Burger King franchises here in Casper. You're talking basically minimum wage employees. They can show you that it is cost effective and saving them money to drug test at an entry level worker.

That is something that each community has to stand up and have the courage to say, if you are going to live here, if you're going to work here, you will be drug free.

The ironic point of that is, we have interpretations of law at the Federal level that protects governmental employees from drug testing. This is absolutely ludicrous. We are saying that they are a protected class of individuals and that this is a warrantless search.

I don't know who came up with that interpretation, but somebody ought to slap him. As governmental employees, we should be taking the lead in drug testing and we should be the example. To hide behind a law or an interpretation of the law is absolutely a crime.

Thank you.

Senator ENZI. Dr. Clark.

Dr. CLARK. Senator, I think it is important for collaboration to occur, and at Substance Abuse and Mental Health Services Administration we are collaborating with, as I mentioned before, the Department of Justice, the Drug Enforcement Administration, National Institutes of Health, the National Association of States on Alcohol and Drugs directors. We're collaborating with State conferences. I would be remiss if I didn't mention that on April 6th and 7th, SAMHSA is sponsoring a conference on methamphetamine in Los Angeles for all States west of the Mississippi River. We're paying for each State to bring up to 15 individuals including State officials and providers. The States on the east side of the Mississippi will have their conference in Orlando the week of May 23rd.

We are working with the National Institutes of Health to get information out as that information matures for dissemination to community providers for facilitating that.

With our Access to Recovery program, we are making sure that we involve community organizations, nontraditional providers, and, as Ms. Martin stressed, focusing on recovery of support services so

that the recovery support services strategy involves nontraditional providers in the community so you get employment services, transportation, literacy, spiritual health, housing, coaching, etc. It's been a very successful program with very little fraud and abuse and active involvement of the community. It is a revolutionary program in the sense that we're using vouchers and empowering individuals to make choices, and that was another point that was being made, because if we don't involve the individual who is using in the process, then we don't stop the process, and where prevention is very, very important, when prevention fails, we have to empower individuals to get treated.

Workplace drug testing is another effort that we support at SAMHSA. If we can create this full continuum from public safety to public health involving communities, whether they're tribal communities, urban communities, rural communities, involving communities, then we can reduce the demand for the drug, at which point we achieve success.

Thank you.

Senator ENZI. Thank you.

Dr. Rawson.

Mr. RAWSON. Senator, in some of the communities we visited, the idea of getting community partnerships together have clearly been the example of the communities that have started to make progress.

In California, San Diego is one of the—because they have had a problem for 25 years, they've really done some very remarkable things, and we have seen some very specifically good outcomes there.

Particularly linking treatment and prevention with some of the activities where they have been able to take people who have had problems and use them in some of the messaging for prevention has been particularly helpful. But I want to talk about one specific partnership that we have seen that we think is extremely important, and that has to do with the issue of drug courts.

In our large SAMHSA study that we did, we had one site that was a drug—where all the patients were in drug court. That site had the best, by far, treatment outcome of all the other sites.

Part of that is because meth users need to be continued in treatment for a substantial period of time. This is not a 30-day fix. They need to be treated over a long period of time, and drug courts and the consequences of drug courts are exactly designed the way you would want treatment to be designed for meth users.

I think drug courts are an extremely important innovation, and I think that for meth users, drug courts really bring together the best partnership between the criminal justice system and the treatment system in an optimal way.

Thank you.

Senator ENZI. Thank you.

Ms. Searcy.

Ms. SEARCY. One of the things that was brought up is having a comprehensive community strategy developed, and I can't reiterate the importance of that. This also needs to be done on a national level as well.

Some of the guidelines that local and State groups need to know about what actually works could really benefit communities as they develop these strategies, and some of those issues fall in with protection of unborn children, treatment services, drug courts.

One of the things that is part of these successful strategies is the multiagency efforts together, so combining medical and law enforcement, child protection services. Oftentimes what we see when that doesn't happen is law enforcement will be going for a Federal jail term or prison term for someone while child protection services with the child is trying to preserve the family and reunify them and treatment's off the hook. What happens is we waste our money there, where if we all come together, we know what's happening and what our goal is for this family or for this individual, that we can have money savings and kind of streamline that process for people to get them rehabilitated.

Community mobilization, I'm talking about with not only clergy, which is very, very important, private businesses, the dental community, insurances—I already stated that—and other people that we wouldn't normally think. We need to bring them on board to help with their solutions, to come to the solution. Schools is another area. Another area would be some of your drug companies. They need to be part of the solution as well as they're being a part of the precursor issue.

Public awareness and prevention has already come up, but what we need to do is not just take something and slap it on our community but really do a needs analysis and find out really where that need is and be really strategic in how we spend our money on this.

Treatment.—Not only do we need to increase the foundation funding that I talked about, but we really need to think about family treatment programs. Salt Lake City just started their first father-and-child treatment program. That kicked off this month.

Drug court.—Dr. Rawson talked about that. Our drug court that we find is very successful actually runs 18 months and the judge sees those individuals. Every 2 weeks, very powerful. Very good outcomes coming out of that. It brings judicial and treatment together. Again, you know, look back at the interagency collaborations with that.

Law enforcement resources.—They continue to need equipment, training for this issue, and investigations is really important. Senator Hatch has done a lot of work off of your committee to that end.

Precursor controls, we love the Meth Combat Act in Utah. All the States around us have precursor controls and we didn't. We knew what was going to happen this year. International controls, not only interdiction but also controls of precursors. We need to think about that.

I'm out of time, so one other thing that Utah has done, is doing right now, is we had local initiatives started. Rural communities are really able to get moving in the right direction quicker than urban areas. We witnessed that in Utah. Governor Huntsman just kicked off in 2006 his meth task force. We're really going to look at drug offenders reformat in Utah and try to get some treatment initiatives going, increase our public awareness and prevention strategies.

Senator ENZI. Thank you.

Sergeant Hamilton.

Mr. HAMILTON. All the Campbell County sheriff's officers used our methamphetamine awareness programs and the department itself has coordinated a step. In the areas of prevention, we have three full-time officers working DARE and a school resource. Also our methamphetamine awareness lectures coordinate with the tobacco use coalition and the underage drinking coalitions in Campbell County.

My wife, Diane, and I are a member of the coalition promoting a drug-free community. For a short period of time, there were conversations that we had maybe too many coalitions in Campbell County, but I disagree. Those coalitions are like individual voices, and people that have specific interests will have a coalition that they will get behind that might avoid it if there were fewer or more combined coalitions.

Sharing the meth problem with as many people as we possibly can is our greatest effort of coordination. We have—Corporal Reynolds and I have talked to more than 2,000 people and given more than 50 of these lectures to schoolteachers, dental offices, hospitals, individual groups such as churches, family groups and shared throughout the five-county area, though in sharing we are actually learning more than I think we share. We learn more about each individual group's concerns and how they can best help and some of their limitations.

I want to say that Chief Pagel hit two things directly on the head that I wanted to speak to, and that was, I believe, the Federal Government, in issuing any grant moneys, they should be based on a community-based plan to deal with this, some community center to collect this information from these coalitions, collect the information that deals with prevention or treatment or enforcement and provide a plan before receiving grant money.

The other thing that Chief Pagel said that I fully agree with is, if he wants to slap the person, I'll be glad to kick the person who has protected Government employees from having to face drug testing. I think drug testing is important, though I know it's, to some degree, easy to circumvent, and last week, not for the first time, we served a methamphetamine-related search warrant, this time on a drug-endangered child case, and removed urine from the refrigerator where it had been collected by this particular defendant from her children so that she could pass these drug tests.

In Wyoming, drug endangered child law is a felony. I find, as I said before, whether it's a felony or misdemeanor is moot. The way our philosophy from the Campbell County Sheriff's Office is these parents need to face treatment, they need to face control by the Department of Family Services. We need to get the families back together, but the family has to be a safe unit and not one that places the children in an environment that they are not just endangered from the drug but endangered from the entire philosophy of the adults that use that drug.

I see this as an incredibly dangerous problem. As I said before, I think it's a problem that enforcement is not just law enforcement. I understand the statement that we cannot enforce our way out of this, though I believe maybe that statement would be more accurate if it was stated we cannot incarcerate our way out of this.

Placing people in incarceration provides nothing, but a broad enforcement, not just law enforcement, enforcement by individuals, whether you're a parent or a teacher or in any form, can help enforce and get people into treatment is eventually the answer, if the treatment is available.

Thank you.

Senator ENZI. Thank you.

Mr. DeLozier.

Mr. DELOZIER. Thank you, Senator.

Most of the things that's been discussed an awful lot, obviously, today is the treatment aspect, and from the standpoint of collaboration with our community, the community that works together on this problem, like this every agency you can think of is involved in this methamphetamine problem.

I think Chief Pagel would agree, there is a couple we would like to get involved in and are working hard to do so.

We have got to have adequate treatment on the back end of this when we get kids into custody. In Natrona County, we took in almost 90 kids in 2005 into protect—excuse me—into custody because of methamphetamine, and that was probably 70 percent of our entire placement case load. If meth never existed, 90 children would never be in a system of foster care. I think we have to recognize, then, and we're starting to realize that adequate treatment for moms especially is one of those elements that's going to get kids home sooner, and proposals that are being discussed now within our agency and within the community, meth initiative includes things like treatment facilities where moms can take their kids with them. Those kids can be placed as long as it takes to be in there with them in a monitored and supervised environment so those attachments are not lost, and, in fact, in many of these cases, those attachments don't exist, especially with very young children or infants.

The goal of building those attachments, keeping those kids from having to enter the foster care system, all of those things involved in that process are very necessary when it comes to the treatment aspect, and we have seen in much of our case work with these meth cases that the more contact the mother has with the child, the more treatment she receives and the greater her ability to focus on things over—that child goes home sooner, or children, depending on the numbers, and that's a real significant issue, I think.

I think we have got a lot of programs within Casper that work really good on the front end and toward the middle, and I think one of our focuses need to be on the back end of that treatment aspect. One of the programs that I'm particularly pleased with is the Natrona County Child Advocacy Project, and we're a member of that, and it's an organization that focuses on interviews of—forensic interviewing of children who have been alleged to have had sexual abuse, major physical injuries, those kinds of things. We have recently started a meth protocol there whereby every child who comes into DFS custody because of meth will receive a forensic interview, a medical assessment, whether that be specific to the meth issue or well child check, and a developmental assessment or mental health assessment, whichever is determined appropriate based on the age of the child. I think it's programs like that that

are going to provide us the direction we need to move these treatment issues forward with moms especially. Some dads, obviously, that we get involved with, are looking toward treatment. The collaboration, I can't say enough about community collaboration.

If all of the key groups in your community are not willing to come together to even discuss it, you might as well forget about dealing with the problem, and that's absolutely critical. Everybody has got to put their turf outside the door and make it happen. That's a very inexpensive thing to do in terms of focused efforts and moving things forward.

Thank you.

Senator ENZI. Thank you.

Ms. Martin.

Ms. MARTIN. I want to come from the perspective of our Access Recovery support service end of it more specifically into ATR, more specifically into the community, more specifically into being a faith-based organization.

There is something that we say in faith, and it really comes out of scripture, it is that you're the arm, I'm the hand, you're the head, you're the toe. That's community coming together.

When we were at the last Access Recovery meeting in Washington, DC., another thing that we spoke about on a faith perspective was this is something the church has been doing for a really long time. We feel like the community—to utilize those aspects of the faith community, faith—or social services actually sprung up out of the faith community.

Then it becomes that aspect of, can we use those resources, when Mr. Pagel discusses, you know, we can't wait for this, we can't wait for that, to use those recovery support services at the emergency level.

One of the things Dr. Rawson discussed was drug courts. Again, understanding what a drug court is, it's a team effort where you have the judges, where you have POs and you have therapists and so on.

In recovery support services, the referrals that we get—it is definitely a prevention aspect—in that referrals that come to recovery support services is not just through the courts. It's through parents; it's through school administrations; it's through other providers. It's actually through pastors now, because some of these kids, some of these mothers and fathers were going to the pastors. They become a referral point into this, so that until they get treatment, we can be working with them until they can get into treatment. When they get into treatment, we can be working with them afterwards to reintegrate them back into the home.

One of the visions that we have and I believe that what I am going to read you is our mission statement for Family Wholeness. I believe this is something that we are establishing here on a local level, an organization that—and I believe that I speak for the different organizations in Access to Recovery.

We are currently establishing a faith coalition here. You were talking about the different coalitions in your community. We also believe that this is one voice in our community collaborating with many other voices in that while we're here, we're establishing a State coalition. While I was in DC. about a month ago, there was

a national alliance established. What I thought was really—I mean, it was just incredible to see this national faith-based alliance for recovery support services come together with CADCA who is a treatment coalition across our Nation. What came out of this meeting was just—I think it was history making in that you had treatment and recovery support services saying we're going to come together and develop a coalition.

One of the things CADCA said, is there—we're hoping that there is a national faith-based organization for recovery support services. It was established the night before.

These two are coming together, and that's huge that you have treatment and recovery support services coming together, because we believe we do represent the community.

I read our Family Wholeness—and, like I said, I believe I represent something in many of the RSS services. Our mission statement is committed to come alongside one individual at a time to facilitate healing, restoration and wholeness within the family. Family Wholeness represents that aspect of it. Division is to have families recovered and healed in order to repair, rebuild and restore healthy communities, cities and nations. The values that we focus on are faith, love, acceptance, relationship and honesty.

I believe those are foundational issues within the family that develop out of the community and the community coming in with the judicial system, with the police department, with treatments, but that we all come together.

Senator ENZI. Thank you.

Mr. Robinson, then the first lady, then Ms. Maki.

Mr. Robinson.

Mr. ROBINSON. Thank you, Senator.

This has been really quite enlightening and powerful for me as you listen to all the details of what we're not up against, but what we're in the process of, and just the last testimony in terms of this, this is really a much larger picture of healing than most of us are aware, because oftentimes we get lost in the detail of what's right in front of us. I couldn't agree more strongly the need for comprehensive planning at the Federal level, at the State level, because there is—when I'm talking about comprehensive planning, it's not just the agencies as much as providing access, real, true access, and I believe Access to Recovery is the basic premise of premises of that is doing exactly that.

It offers and opens up the arena, if you will. It opens up the continuum to the communities where 80 to 85 percent of recovery really has to happen, whether we're arresting them, charging them, treating them. We're only able to do a portion of what needs to be done, and the reality is these same folks, humans that are suffering through addiction have to step back into everyday life, and if we don't have those kinds of support, whether it's a full service continuum, holding hands with a recovering community, building a recovering environment, then we fall short.

As I had indicated earlier, you know, we have been frustrated over and over and over again when we look at the research to show what segmented or truncated services are attempting.

I think we're entering into an era where we're finally forgetting the turf, as was mentioned earlier, and we're starting to look at

what is best for the individual. As soon as we do that, we start to look at the fact that everything is prevention. From the womb to the grave is a human condition that we have to pay attention to.

When it comes to substances, even though I have been doing, "intervention and treatment" for the last 26 years and most recently just getting a very voracious appetite for research in terms of what is working and what is not working, I couldn't agree more with the first lady that we have to expand our thinking to see it all as a part of prevention, intervention and long-term overall recovery for human beings.

I had the opportunity to work with the State here back in 2001—the courageous legislators—legislators that we have and Governors that we have to really stand right in the face of changing the norm with a lot of what's been going on in past years in terms of our approach to prevention, intervention and treatment.

We were developing standards of care or revising these standards of care, and so they gathered a room like this of very well meaning, very bright, accomplished individuals to set out, what do we need to look at for a new set of standards of care, if you will, for prevention, intervention and treatment. Within the hour, you could just feel the frustration and the tension in the room, because what we were very methodically doing is building the same tire that we had built years before and before that and before that. It was basically a male institutional, fairly aggressive approach to treating addiction and trying to achieve recovery and, you know, that just being three or four elements of it.

There was a lot of good going on, but there was that frustration in the room. Finally, Diane Galloway at the time who was the division administrator, said she looked across and there was one of our sisters, colleagues from Wind River country, Kelly. I'll say her first name. She was sitting there, and she works right in the trenches. And she said, "Kelly, what's written on your face? It's frustration, obviously."

But she said, "You know, I'm just tired of sitting here and listening to all of this." She said, "If we really want to start thinking outside the box, maybe we need to consider throwing the box out completely and looking at the fact that if we were to develop a service system that treated women and children instead of the male institutional—nothing against medical, but primarily medical model—we would be so much better served, because not only would the children—the women and children finally get an emphasis on what their needs are, the men would be treated just fine as a result of that."

You could have had heard a pin drop in the room. After what I imagine was just a few seconds, the discussion started back to develop, an institutional male—dominant male punitive approach to this.

I think with the testimony that we're getting around the table, we have got a phenomenal opportunity to really, I think, start not thinking outside the box but throwing the box out, because we have got models that are absolutely working in Wyoming, and it would be wonderful if we had the opportunity to share some of those models.

Thank you.

Senator ENZI. Thank you.

First Lady Nancy Freudenthal.

Ms. FREUDENTHAL. Thank you.

I was pleased to hear Mr. Robinson say he thought we were more successful putting turf outside the door.

That's a huge challenge. One of the things that the First Lady's Initiative inadvertently really has been successful with, whether you're talking about State agencies or Federal agencies, they each have their bureaucratic turf and they also perhaps even more challenging have their natural partners. When you're dealing within that framework, I think it's important to look at these plans and challenge agencies on how they are going to share the responsibility for this issue and bring in not only their natural partners but partners that they're not so accustomed to working with.

Through the First Lady's Initiative, and I say inadvertently, because I'm a volunteer and I suspect perhaps the one with the least amount of turf, because, other than the Governor's residence small budget, I don't have any money, I don't—I just know people with authority. But perhaps because of that, we were able to appeal to partners that, I think, if the initiative had been just under the Department of Health or just under the Department of DFS or just under the Department of Education, now, some of those partners would not be part of our success. I just think that that's part of the challenge with government—that they have built up these silos and up into the silo come their natural partners, and you have a whole framework of really good allies that end up either feeling excluded or just not comfortable working in that model.

I mean, we have managed to partner with—our law enforcement partners have been the strongest and most consistent partnership. We have State agencies, including the Department of Transportation as partners. We have got liquor and beer distributors and retailers as our partner. I partnered with Anheuser-Busch and mailed out 16,000 letters to families just recently on talking to their kids about the challenge of drinking.

I couldn't have done that by myself with no funding. We have partnered with military, judges, and business owners. The faith community has been a tremendous partner of Wyoming faith initiatives. The nonprofit sector, teachers and school administrators, local governmental officials, parents and students, again, to really try to change norms around the issue of childhood drinking, to change the thinking that it's just alcohol, it's not drugs, when we know that that's where too many of our children are heading.

As you know, I'm still practicing law, and I was taking a deposition a while back. And this young lady, who, by the time of trial, was pregnant, she pretty much said, well, she started drinking very early, and on that particular night, they would have bought some meth but they just didn't have enough money.

We know that that's the course or the ramp that our children are on if we're not paying attention to it and we just shrug off the issue of childhood drinking. But with the team members, we have managed to really empower local communities. We have had great discussions from where the beer tent is at the local fair, to why parents are hosting kids' drinking parties, to what the school policies

are in our schools. We have published a lot of best practices. We have put ordinances out there for communities to consider.

Because I'm not a State employee, I lobbied the legislature on changes and have worked with many others to have Wyoming pass the social hosting statute and keg registration statute, and I think the Governor just today signed the ignition interlock law.

We're excited with SAMHSA's support to put on televised town hall meetings through Wyoming Public Television with—and we're going to be doing kind of a simulcast program all around the State on April 6th on the—and bringing in panels and encouraging community discussions about how they see their community, do they see a problem there and where do they see the direction that their children are going.

I echo everybody's comments that partnership and inclusion is so very important, and I wish that I had the answer at every level of government to a model that brings in the broadest range of partners. But I do think, you know, as you look at these individual agencies, that it's not easy for them to collaborate, and I think that that's the key to this and collaborating clear down into our small rural communities. Using technology and being more creative is a huge challenge, but it's worth all of the effort and thought.

Thank you.

Senator ENZI. Thank you.

Ms. Maki and then Mr. Sniffin.

Ms. MAKI. Senator, thank you.

If I can maybe just encompass what we have been hearing and again and again, we all have come to this table with very much a similar message. One of these messages—I think this is a full court press type operation.

Every one of us is extremely important to solving and coming against methamphetamine. One of those ways, one of these full court press measures is certainly prevention, and if I can back up with what the first lady mentioned about prevention and how it relates to methamphetamine.

When we're talking about prevention of nicotine and alcohol, kids that reported that they had been habitual smokers also reported they were eight times more likely to also use methamphetamine, when we're talking about alcohol and nicotine, eight times, six times more likely to use methamphetamine. It plays right into this struggle that we're seeing.

As far as treatment, at the substance abuse division, House bill 91 is part of our appropriations. What did we see come out of the legislature this year? One thing is they were going to continue funding the original number of beds that were set out last year as far as residential treatments. They were going to increase the reimbursable rates by 15 percent for treatment providers. They are going to increase social detox beds, 12 beds across the State.

I think many of us that are sitting in this room are thinking we're going to need more. One of my jobs as well as others around this table is to help get that message out to legislators. We need to continue to be able to do that.

Backing up to prevention, when we—let me mention, too, that the prevention framework, those grants, those prevention grants,

those are really important that these moneys continue to come into our State.

Also, there currently, as far as I'm aware, are no research-based prevention modules specific to methamphetamine. But let me just put it on the table. Does it mean that we can't talk about that in our schools, meth-based prevention in our schools?

And then communities, that's another thing that we have been hearing again and again today. Full court press means all the way from the Federal level through the State down into the communities, and one way that at least at the Federal level that I see could help out in your communities is, if I can say to a community initiative or whatnot that often contacts me or others here, can you apply for this grant? We have got drug-free community type grants. There is at least one that I know of. If we can get more money to those communities, that also is through a process, a strategic process that these communities are building that we can then help fund them to help them get this off the ground.

Thank you.

Senator ENZI. Thank you.

Mr. Sniffin and then Mr. Noseep.

Mr. SNIFFIN. Thank you again, Senator. I won't talk quite so long this time.

I guess if I were to say one thing, I don't think the public is passive on this issue, and I think there is a lot of work to do, but I think especially in rural America there is a willing public and a willing media. We have huge scrapbooks of the media that, in this State, that step forward and really has, so you just always include the media, because they want to write about this and they want to help in every way. That's a great way to get the message out. Again, it's not just advertising and it's not even PR. There is a thing called earned media and it's a whole concept that I think really works very well in covering a story of this magnitude.

Thank you.

Senator ENZI. Thank you.

Mr. Noseep.

Mr. NOSEEP. Thank you, Senator.

I realize sometimes that the Wind River Reservation to outsiders is a mystery, and it's not. There are 13,000 residents that reside within the boundaries of the reservation, and of those 13,000, there are a lot, a lot of good people, and we do the same things that everybody else does, and we have the same problems that everybody else does.

Those people have realized that this poison has the potential or did have the—still does, the potential to wipe out two nations, two Shoshone and Arapaho Tribes. It has that potential to take them out, and they have realized it.

In 2004, we had our first annual methamphetamine awareness conference. Not too many people showed up that first year. In May 2005, we had our drug bust, if you want to say. The next month, we had our second annual methamphetamine awareness conference, and then the people came out.

I think it took some action to make people realize on the reservation that if they report people or if they want to help out law enforcement, that something is going to be done. It took that, I think,

to get the ball rolling. Now we're having our third annual methamphetamine conference coming up in June, and also out of that is the Partners Against Methamphetamine. It's grass roots. Community people have gotten together, and I'm thankful for that being as, you know, law enforcement can't do it by ourselves. The people are starting to come out and pitch in their ideas of how to combat.

For us, prevention, enforcement was kind of the first phase for us and prevention will be the second phase. We do gang resistance in the schools. We're kicking our gang resistance along with our methamphetamine awareness stuff even down to our 2nd and 3rd graders. And so we're going to start 2nd and 3rd graders.

As sad as that is, we have got to take it down young. We were in the 6th grade building, but the 6th and 7th graders we felt were well aware of what was going on.

You get down to the 2nd and 3rd graders and they can retain this information and they know what's going on out there already.

We want to get to those guys and also tribal elders. Elderly were mentioned before. For us, the Shoshone and Arapaho Tribes, the tribal elders are held in high regard. There is a high amount of tribal elders that have custody of their kids' kids, grandkids, nieces, nephews. They have a whole houseful, and to get the prevention out to the tribal elder society so both sides is going to be one of our priorities.

We have had a lot of them. Last year's sun dance, I remember a couple of them coming up to me, just wanting to know what the basic paraphernalia looked like, what it was, what it looked like, and then them telling us, "Oh, I had it in the house," or, "I seen it last week."

To get to the tribal elders, I think, that was actually one of our priorities. At the conference you attended yesterday, I was talking to a father about his son who was on meth. It was funny saying that—I said, "Man, your son was in jail for 30 days." He was in on meth. He came in high on meth, and we were talking about it. After talking to him, I said, "Man, your son looked good." I said, "He was gaining weight. He got his color back, no black rings around his eyes." After I got to thinking about it, we do that all the time now. Now all of a sudden, gaining weight is actually a good form for us.

I said, man, in this day and age of dieting and staying in good health, now a sign of weight gain is a good sign for law enforcement. We got to looking around. That's exactly what has happened to a couple of our guys. For us, sometimes jail on the reservation is the safest place for some of these guys. His son had actually thanked us for picking him up, and he dried out in 30 days, but unfortunately had to go to Idaho to take care of a warrant. He's still up there.

But all is not lost. We're in it for the long fight and so are the people of the Wind River Reservation.

Thank you.

Senator ENZI. Thank you.

Doctor Christensen. Did you have——

Dr. CHRISTENSEN. Just an observation as a doctor citizen and not doctor dentist.

There was a meth treatment center ballot initiative down in Sweetwater County last year. The voters down there had the wherewithal to build a meth treatment center, had they wanted to, but the initiative was defeated rather soundly. The word on the street, if you talk to people about why they did or didn't vote for the meth treatment center was that: It doesn't work anyway. They put these people in meth treatment. They get out and they start all over again. Why should we waste our money on that?

I think that people who are involved with collaboratives and coalitions and all of the right things need to do better education about the success of meth treatment if they're going to convince folks to build meth treatment centers, support meth rehabilitation.

Senator ENZI. Thank you very much. I want to thank all of the panelists for the time and the preparation and the travel and everything that had to go into this.

It's been a tremendous education for me today. There are a lot of useable things. I've got pages of notes.

Now, the down side: I have also got some additional questions. I'll be sending some of you additional questions, some things that I may not have understood or that I want more detail on so that we can make more extensive use of it.

There may be other members of the committee that will want to ask questions, and I would ask that you respond on that as quickly as possible so that we can make it a part of the record.

I do want to thank several people for helping to organize this. One of them is Denis O'Donovan. He works for both parties in organizing and setting up and making sure that equipment is in place, and if we vote, he calls the roll as well. He's been doing this for a number of years and is very expert. We're very fortunate to have him.

From my staff, Michelle Dirst helped put this together.

Want to raise your hand?

The head of all of my health issues is Steven Northrup. Other people that I have with me here are Cherie Hilderbrand, who works in the office here in Casper. She is sitting in the back.

If any of you in the audience have something that you want to contribute to this testimony, we would be happy to have it. You might drop it off at the office there or you can put it on the committee Web site.

Robin Bailey I think is here. I know she was—yes. She is my State director. I have five offices across the State. She makes sure that all five are coordinated and she goes to Federal meetings in Wyoming when I can't be in Wyoming to go to them.

DeAnna Bruski is here. She's from the Gillette office. I didn't mention Elly Pickett, too. Elly is my deputy press secretary.

Mr. Sniffin mentioned the importance of media involvement. We want the word to get out to more people than are just in this room, and we do appreciate the media's help in doing that. It makes a real difference.

I also want to thank Rodger McDaniel for being here today and sitting through the entire testimony. He's a tremendous resource for us, and his expertise is very much appreciated, and now he's got the background of the hearing as well.

We'll look forward to some more information from you.

I would mention when I was in Casper 2 weekends ago, when I got snowed in in Casper, I met a chef here in town who was a recovering meth addict, and he's been clean for 3 years and was pleased with that, and so was I. He's a part of this community effort of going around and talking to kids about what can happen to you. I really appreciate that.

I also had some people come to my office. They had a little drug testing kit. We talked about drug testing a little bit, and I'm a huge advocate of drug testing. It was in a fancy little box, and it's called "Not My Kid." This group meets with parents whose kids are in—I believe it's in 4th grade. They give the parents the drug testing kit and also little talking points that they can talk to their kids about drugs, but they don't test the kid. The purpose of that little test kit is to go on top of the refrigerator where the kid can see it all the time and when he's out with his peers and they're putting pressure on him to use some kind of drugs, they say, "Whoa. No. My folks have a drug testing kit. I could be subjected to that. I can't do this." And evidently it's working.

We like all of those ideas. I appreciate Senator Hatch and his work in Utah and also on the committee. He's a former chairman of this committee. But we have a lot of great people on the committee, both sides of the aisle, who are definitely interested in this and getting the SAMHSA reauthorization done and a number of other bills.

Thank you all for your participation today. This has been tremendous. Thank you very much.

This hearing is closed, but the record will stay open for 10 days.

[Additional material follows.]

ADDITIONAL MATERIAL

RESPONSE TO QUESTION OF SENATOR ENZI BY JAMES DELOZIER

Question. It is clear that children are the true victims of this drug. Therefore, how do we create resilience in children affected by this drug, and a stable environment that will allow them to live up to their full potential?

Answer. From the Department of Family Services standpoint, we create resilience in these meth children by ensuring they are safe from harm, that they receive appropriate care through relative or non-relative foster care, that their parents are given an appropriate opportunity to rehabilitate (in cases where it is appropriate) in order that the children may go back with them and be safe. When kids can't go back to their own homes, expedited permanancy through adoption is the best option to give them a sense of connection to family, even if it is a new family.

Kids can't be allowed to grow up in those kind of homes without intervention because they will repeat the cycle of abuse in one form or another, or many, when they become adults.

There are a few very specific reasons in the Federal Adoption and Safe Families Act which allow DFS to move to terminate parental rights without making reasonable efforts to rehabilitate the parents. Examples would be parent having murdered another child, parental rights were terminated on a previous child, etc.

I would recommend that law be revisited to add to that list children moved from homes because of use of methamphetamine, manufacture of methamphetamine, sale of methamphetamine or both. Use itself is a complicated issue because it involves addiction and treatment issues.

Use by a parent puts children at risk no doubt and is associated with selling and producing the drug a lot of times.

Kids coming from homes where labs are found and selling is happening are exposed to deadly chemicals and all kinds of health hazards in a very severe sense. Also, children in these homes are frequently at risk of other major abuses such as sexual abuse, physical abuse, severe neglect, malnutrition, medical neglect; the list is endless.

I think it would be appropriate to have meth be one of the variables upon which the agency could seek termination of parental rights immediately without making reasonable efforts to reunify. Jurisdictions would then have the ability to exercise these options if the case elements were determined appropriate and evidence present.

I know the Constitution gives parents the right to associate with their children. However, this is a severe health crisis and many children are paying the price for their parent or caretakers involvement with methamphetamine. I think at some point society needs to draw a line in the sand and say "if you do this, you lose the right to associate with your children." This may seem a harsh viewpoint coming from a social services professional but having seen so much of the meth issue now, some individuals need to be dealt with harshly when it comes to this treatment of their children, and the children need to be able to move forward from the issue as quickly as possible.

RESPONSE TO QUESTIONS OF SENATOR ENZI BY ROD ROBINSON

Question 1. You mentioned the importance of using a full continuum of care model when treating meth. Can you describe more in depth how such a model works and how you work with other entities?

Answer 1. There are two main components to WYSTAR's continuum of care:

First, WYSTAR focuses on a "recovery model" rather than on a sickness or disease model. Under the recovery model, WYSTAR helps clients assess and plan for using their strengths and what is right with their lives. By contrast, a sickness model tends to point out the problems with clients and highlight what is wrong with them. The sickness model is further predicated on the assumption that the "professionals" have all of the answers needed for the client to get well.

What clients tell us and what our experience is showing us is that it is easier for clients to respond to a recovery model instead of a sickness or disease model. When treated through a sickness or disease model, clients tend to resist treatment both at the onset of treatment and throughout the course of the services.

Under a recovery model, our clients are much less likely to resist change. By combining this recovery model with trauma-based therapy, we help our clients discover the underlying cause of their illness and, thus help them find their individualized path to sustainable recovery.

Further, our clients tell us that the full continuum service matrix model that we use allows them to not only see their strengths, but to also see very clearly how they are making progress and where they need to focus more attention (a more detailed description of this matrix model was distributed at the HELP Committee roundtable in Casper).

Second, WYSTAR couples this recovery model of treatment with a full continuum of care. This means that we strive to work with our clients in a stepped-down fashion from immediate intervention to primary treatment to recovery home living combined with outpatient services. This stepped-down treatment allows us to work with our clients over a longer period of time at a lower cost than primary treatment over similar durations.

Throughout this continuum of care, we aim to identify critical craving thresholds and seek to address identified relapse stressors. In lay terms, this means that during our full continuum of treatment, we seek to identify those points in time during which our clients are most likely to have cravings for the substance to which they are addicted. By identifying these craving thresholds, we can better tailor our treatment to respond to such craving episodes and can also create space within our treatment continuum for life-skills training, job training, and other skill enhancements that help our clients respond to relapse stressors once they have left primary treatment and begun re-engaging in society.

As our clients stabilize in each of the stepped-down levels of care, they receive tangible evidence that they are moving forward in building their long-term recovery momentum. Our clients also tell us that it is a relief for them to know that if they start running into difficulty or if relapse stressors start to present, they know that our continuum approach allows for them to step back up to more intensive services until they have re-stabilized and then they can step back down in service. The continuum acts as a safety net as well as a stabilizer. Our clients tell us that being able to practice recovery within this framework gives them the confidence that they can and will succeed in long-term recovery.

Throughout this continuum of care, WYSTAR has sought to create community partnerships at every turn. All too often, the societal stigma associated with addiction contributes to relapses following treatment. By working cooperatively with a broad cross-section of the community, WYSTAR seeks to create nothing short of a recovery environment—a community that embraces people in recovery, helping them to obtain the skills they need to reenter society and helping them to remain gainfully employed following treatment.

In particular, WYSTAR is currently working with drug courts, local employers, Sheridan College, the city of Sheridan, Sheridan County, Sheridan County Memorial Hospital, and many others to establish and enhance our continuum of care and to create a recovery environment in Sheridan, Wyoming.

Question 2. You mentioned that NIDA-funded addiction-based research projects are not being funded in Wyoming and surrounded States. Can you describe the research currently underway by WYSTAR and more specifically how it is being funded and how you plan to disseminate the information?

Answer 2. WYSTAR is currently conducting three research projects relating to the effectiveness of our treatment protocols.

First, we are 18 months into the Women's Trauma and Addiction project that has been following 30 women to determine what elements of care were most important and effective for them in their treatment at our agency. We recognize that ptsd/trauma is one of the primary contributing factors to their onset of substance use and is one of the most significant barriers to long-term recovery. Until our female clients are able to grieve their losses, they are more than likely going to repeat the same behaviors that keep them stuck in traumatic relationships. We can share more of the formal study protocols and findings if you wish. The study was paid for by the Wyoming Department of Health, Substance Abuse Division.

Second, we are pursuing a study funded via an earmarked grant that Senator Thomas helped to secure through SAMHSA. The grant is being used to assign four treatment beds at WYSTAR's women's facility to follow clients through a full continuum of care from primary residential to transitions to outpatient recovery support. In this study, we are attempting to determine the appropriate length of stay that is needed for women in rural America and the types of services that they are most in need of to ensure sustained recovery over time. Again we have formal study protocols that we would be happy to share.

The third study that WYSTAR is currently pursuing is funded by the Wyoming Department of Health, Substance Abuse Division. We are following five primary methamphetamine men's beds through the full continuum of care to determine what is the most appropriate length of stay for methamphetamine treatment in rural

America and to identify the services that are most in need for our clients to attain sustained abstinence and long-term recovery. This study is highlighted in handouts that I distributed at the roundtable that show the clients in this study achieving a 90.1 percent rate of abstinence and recovery at 6 months. While these preliminary results are exciting, we recognize that the sample size is small and the project is only funded for 9 months, which is far too short to fully assess the success rates for this treatment protocol. In subsequent studies, we would like to tract a larger sample of clients over a longer timeframe—18 months or longer—so that we can begin to definitively identify treatment options that are most successful for addressing the rural methampethamine crisis.

WYSTAR is conducting all three of these studies on a shoe-string budget, which does not allow for the rigor of publishing and dissemination. Nonetheless, WYSTAR has initiated these studies based on the recognition that too little is currently known about the effectiveness of treatment in rural America. Rather than continuing to administer "blind treatment" we took it upon ourselves to set the stage for formal research simply because nobody else seemed to be interested in doing so. WYSTAR is very interested to deepening our research efforts and intends to work toward establishing a rural research institute on addictions. We would welcome the opportunity to talk in greater detail about this concept with members of the HELP Committee.

Question 3. You also mentioned that you are using the UCLA model for tracking clients and have adapted it for rural Wyoming. Can you describe this model more in-depth and explain how you adapted it for rural areas and the resources you use to implement it in your programs?

Answer 3. Unfortunately, our staff that administers the UCLA-modified tracking system is currently unavailable to provide additional detail on this topic at this time. With the committee's permission, WYSTAR will provide an answer to this question next week.

Question 4. What has been the best deterrent for recovering meth addicts to avoid relapsing?

Answer 4. It is our assessment that our wellness and strength-based approach has helped empower our clients, as we teach what is right with them, what strengths they possess and how to operationalize these strengths. The launching platforms for this approach came from the Project Match study completed by NIAAA that looked at the strengths of cognitive, motivational and 12-Step facilitated therapies and also from the Heart and Soul of Change study by Miller, Duncan and Hubell published in 2000.

Further, we believe that our full continuum approach has been highly effective in securing client buy-in to recovery and, by extension, has served as a highly effective deterrent preventing relapse. As mentioned above, we use several different tools such as the Recovery Schedule that helps client structure their time and track their craving thresholds, which in turn helps us help them to plan for the inevitable stressors that they will encounter on their road to recovery. The ASAM criteria has been a tremendous tool to use to help clinicians and clients understand the predisposing factors of addiction, relapse and what areas of a person's life need to be paid attention to.

The simple answer is, that as providers we need to steer clients toward proven methods that they can use to avoid physical, psychological, environmental and societal relapse "traps."

I hope this lends some clarity to why WYSTAR uses the approaches that we do and why we feel it is so important to find ways of sharing our success with others.

RESPONSE TO QUESTIONS OF SENATOR ENZI BY ANNA MAKI

Question 1. What approaches or programs have been effective in reducing meth use amongst adolescents?

Answer 1. The most recent Youth Risk Behavior Survey (YRBS) reported a significant decrease in the use of methamphetamine by Wyoming high school youth. In 2003, 11.6 percent of high school students surveyed reported that they had used methamphetamine at least once in their lifetime. In 2005, this figure had decreased to 8.5 percent. While this decline is worth celebrating, it is important to realize that these figures only represent a moment in the data. Wyoming plans to continue their efforts and propose future objectives in order to maintain the decreasing trends in methamphetamine use by youth.

Wyoming cannot attribute this decrease to one specific approach or program; there are numerous strategies that may have contributed to the decrease. A number

of "full-court press" measures have been in operation in Wyoming that may contribute to the decrease.

PREVENTION MEASURES

Prevention measures for alcohol and nicotine continue to be operating in Wyoming. Wyoming has observed a steady 10-year decline in both alcohol and nicotine use by teenagers. This decline has been accompanied by a decrease in methamphetamine use reported by high school students within the last 2 years. Data from upcoming years will be important in determining the continuation of these decreasing trends. The Division will continue its focus on tobacco and alcohol prevention efforts, which we anticipate will contribute to the reduction of methamphetamine and other illicit drug use. Meanwhile, the Division realizes that methamphetamine also deserves its own public health focus.

SOCIAL MARKETING & MEDIA

In the late 90's methamphetamine began to receive attention from Wyoming media. Continual media coverage of the topics related to methamphetamine has been key to keeping the issue on the fore-front. Additionally, the Wyoming Department of Health, Substance Abuse Division began a social marketing campaign targeting methamphetamine awareness. The first stage of the campaign focused on overall awareness of the dangers associated with methamphetamine. Billboards, TV ads, radio and print features had one common theme "Wyoming Faces Meth." The billboards, displaying individuals before and after their meth addiction were especially effective, as reported in a recent survey (500 respondents, conducted by Lindsey and Associates, 2005). Many of the creative concepts featured young, Wyoming-faces talking candidly about their experiences with methamphetamine. The second phase of the campaign, which the Division is currently directing, focuses on the theme "Treatment Works." This phase of our campaign educates Wyomingites on the benefits of treatment for addiction, urging them to seek help for themselves or friends and family members.

Currently the Division is in the contractual process with Partnership for Drug Free America. As an affiliate member of the Partnership, Wyoming will receive social marketing materials (radio ads, tv ads) that have been developed by top marketing firms across the Nation. A number of these ads are directed to the teenage population. These Partnership materials will be accompanied with additional marketing materials targeted to the school-age population.

JUVENILE DRUG COURTS

There are 6 drug court programs specific to juveniles within Wyoming. Forty percent of juvenile drug court participants report use of methamphetamine. Based upon a comprehensive drug court survey conducted by Wyoming Survey and Analysis Center (WYSAC), most adult clients, juvenile clients, and parents believed that their participation in the Drug Court Program would help them abstain from both substance abuse and criminal activity. Additionally, most drug court clients felt that participation in the Drug Court Program had improved their life circumstances. The majority of adult, juvenile and parent respondents said that family relations, self-esteem, employment/school, drug/alcohol abuse and their overall quality of life had improved since beginning the Drug Court Program.

HOUSE BILL 308—$1 MILLION FOR METH PREVENTION

The Wyoming Legislature, in 2005, allocated $2 million (one-time funds) to increase the residential treatment capacity in Wyoming. Additionally, the legislature slated $1 milllion (one-time funds) for prevention measures related to methamphetamine. These monies were allocated to programs throughout the State via a Request for Proposal (RFP) process. The intent of the funds was to provide prevention strategies for the families and children of those individuals in treatment for methamphetamine. The specific strategies vary amongst programs based upon their initial proposal. A number of the programs include parent education to help families develop skills to improve family relations, increase family cohesion, develop better communication skills and decrease problem behaviors and conflict.

COMMUNITY INITIATIVES AGAINST METHAMPHETAMINE

We know from tobacco and alcohol prevention and other prevention efforts that several elements are key in the prevention of drug use:

1. A community coordinated effort is essential.

2. The community must look at its own landscape and assess its own needs (with technical assistance and guidance from the State).

3. It takes the whole community—multiple efforts—it cannot be left to law enforcement or schools or health departments or parents. Rather, efforts from all parties are essential.

Community initiatives against methamphetamine are rising up all around Wyoming. These initiatives have developed in conjunction with the rising awareness of the issue. Community members from all sectors are making efforts to coordinate responses to methamphetamine. These include the development of regionalized policy surrounding drug endangered children, environmental issues related to meth, drug testing policies, and increasing overall awareness about methamphetamine in their communities.

These approaches have begun to create an environment in Wyoming that is certainly aware of the devastation methamphetamine causes. Communities are talking about the issues, schools are hosting health fairs that include information on substance abuse including meth, high school students with experience using methamphetamine are speaking about their experiences to peer-audiences in formal conference, seminar and focus group settings.

FUTURE OBJECTIVES

Current research does not offer any best-practice approaches to prevention for methamphetamine. However, the State of Wyoming is currently in the planning stages of adding a prevention component specific to methamphetamine. This meth prevention component will be planned around the Strategic Planning Framework promoted by the Center for Substance Abuse Prevention (CSAP). Planning for the meth prevention strategy is currently in an infant stage. However, we realize several elements are essential as we move through the planning process. First, it is unwise to implement or suggest prevention strategies until the need and the intended outcome are identified. Prevention strategies can then be rolled out to specifically address the need while also directly affecting the intended outcome. To initiate a successful meth prevention campaign, new strategies to collect meth-specific data and the information on surrounding issues, must be developed.

Question 2. Understanding that meth has spread to every part of the State, how have you worked to ensure that areas, especially rural areas have access to the most up-to-date information and resources to treat and prevent meth use?

Answer 2. *Social Marketing/Media*—Radio and newsprint are the primary means that Wyomingites receive their information, especially in the most rural regions of the State. Local media has been instrumental in keeping methamphetamine issues on the forefront. The Division and their media contractor have developed radio spots, and newsprint related to methamphetamine. Additionally, the Division has developed an extensive user-friendly Web site which includes a directory of all the certified treatment providers, levels of treatment provided, and contact information. The site also provides a number of resources via links. This enables citizens to access resources quickly and efficiently. Most recently, the Division purchased half page and quarter page newspaper ads in papers all across the State. A number of these papers service the most rural regions. These print ads carried the message that treatment works and advised readers of the treatment facilities located in their specific areas. These ads also complemented the billboard messages that were posted throughout the State.

Community Trainings.—In 2004–2005, Wyoming Department of Health Substance Abuse Division personnel (and grant awardees) were invited by communities to provide over 100 public presentations reaching well over 10,000 people. A number of these presentations were given in small communities as the Division realizes the importance of educating rural communities regarding methamphetamine issues.

Treatment Facilities and Certification.—The Division provides on-going training to treatment professionals through several means. The external certification entity, Center for the Application of Substance Abuse Technologies (CASAT) travels throughout the State providing day-long education on a monthly basis. CASAT is involved in providing one-on-one support to the treatment community for questions and clarification on various treatment related issues, as well as performing the certification evaluations and site reviews.

Question 3. Can you describe continuum of care models in Wyoming that have been effective?

Answer 3. Several substance abuse programs in Wyoming do provide a complete continuum of care either within the agency, or by utilizing other community agencies for "wrap around" services. The continuum of care begins with intervention and,

if needed detoxification, followed by treatment (either outpatient, intensive outpatient, and residential). The most successful models include a post-treatment services component and transitional housing and support. Currently the latter is not widely available in all Wyoming communities.

In Casper, Wyoming, Wyoming Access To Recovery (WATR) has contracted with existing service providers certified to provide addictions care using the American Society of Addictions Medicine (ASAM) Level 0.5 to ASAM Level 3.5. WATR established a Centralized Intake Unit and an independent Clinical Assessment Unit to establish independence from those contracted to provide services. Faith Based Organizations (FBO) have united to provide recovery support services. These non-traditional services re-socialize the clients by engaging them in social activities, developing relationships with other attendees, and establishing mentoring relationships with program facilitators. Recovery support service reimbursement assists both secular and faith-based Recovery Support Providers to develop the capacity to fill in any existing gaps in the prevention, intervention, treatment and aftercare continuum of care.

At the current time, the Substance Abuse Division is unable to gather program specific data to enable a measure of effectiveness of continuum of care programs.

RESPONSE TO QUESTIONS OF SENATOR ENZI BY MR. RAWSON

Question 1. It is clear from the testimonies we are hearing today that meth is fiercely addictive, and that individuals can be hooked from using just once. This makes it more difficult to target one specific population at risk for meth use. Therefore, how does an individual have access to treatment that fits that individual's need?

Answer 1. First, meth is a powerfully addicting drug. So are cocaine, heroin and nicotine among others. The "one time and you're addicted" idea is a myth.

Based on what we've seen to date, we can identify groups at risk. Meth users are 50 percent male and 50 percent female. This is a much higher percent of women than we have seen with other drugs . . . women are at high risk. Gay men are at risk; increasingly young people are at risk; workers in high fatigue jobs, Native Americans and increasingly Hispanics.

"Treatment to fit an individual's needs" is an ideal, almost a platitude. Of course it is good to make treatment to fit needs, but the truth is, if we could get people to use good solid treatments for meth and be properly trained and actually use this material (rather than just do what they have done for the past 30 years), we could make immense progress in treating meth users. In some cases, this mantra of "treatment that fits needs" is an excuse for doing what you want to do and are comfortable doing rather than learning anything new.

If the areas treating meth users actually could get their treatment professionals to use strategies that have been proven effective with stimulant users by NIDA and SAMHSA, they could make major progress.

Question 2. What has been the best deterrent for recovering meth addicts to avoid relapsing?

Answer 2. Drug courts are very useful. With voluntary patients, a technique called contingency management is very useful.

I can give you more information if you want. I've attached a brief treatment article for a semi-lay article.

[Whereupon, at 3:37 p.m., the committee was adjourned.]

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